A

# Dr Hari Krishnan & Anor v Megat Noor Ishak bin Megat Ibrahim & Anor and another appeal

B

FEDERAL COURT (PUTRAJAYA) — CIVIL APPEAL NOS 02–21–03 OF 2015(W) AND 02–26–04 OF 2015(W)
RAUS SHARIF CHIEF JUSTICE, AHMAD MAAROP CJ (MALAYA), ZAINUN ALI, ABU SAMAH NORDIN AND RAMLY ALI FCJJ
14 DECEMBER 2017

C

*Tort — Negligence — Medical negligence — Claim for damages — Complications after underwent retinal detachment operation — Patient suffered from extensive haemorrhage to right eye and became permanently blind — Whether injuries and loss of vision caused by negligence of doctor, anaesthetist and hospital — Standard of care in medical negligence — Applicable tests — Whether breach of duty by doctors to explain risks specifically — Whether patient deprived of chance to make informed decision — Whether doctor negligent in choice of procedure in treating patient — Whether anaesthetist failed to keep plaintiff anaesthetised completely — Liability of doctors*

D

E

The first respondent ('the plaintiff') had a giant retinal tear with detachment in his right eye and consulted the first appellant ('Dr Hari') at his private clinic. Dr Hari advised the plaintiff to undergo a retinal detachment operation immediately and performed the operation ('the first operation') on the plaintiff at the second respondent ('the hospital'). The plaintiff later complained of continuous pain and strong pressure in his eye. Upon a physical and visual inspection, Dr Hari informed the plaintiff that the retina of his right eye had folded outward and that a second operation had to be carried out to repair it due to the urgency of the situation. The plaintiff requested for a scan to confirm the findings but was told by Dr Hari that it was not necessary. The plaintiff initially requested for the anaesthetic services of Dr Manavalan, who had been his anaesthetist for the first operation but Dr Hari assured him that the anaesthetist on duty, the second appellant ('Dr Namazie'), was equally competent. The second operation was carried out and when the plaintiff regained consciousness, he was informed that some problems had occurred during the second operation: the plaintiff had regained consciousness during the operation and bucked while Dr Hari was strengthening the retina using a laser. As a result, the plaintiff suffered Supra-Choroidal Haemorrhage ('SCH'), an extensive haemorrhage with profuse bleeding in his right eye. Subsequently, the plaintiff experienced severe pain, continuous bleeding and a total loss of vision in his right eye. In a medical report, Dr Hari confirmed that the plaintiff's right eye was permanently blind due to retinal detachment. The plaintiff filed a civil suit against Dr Hari, Dr Namazie and the hospital, alleging

F

G

H

I

that the injuries and loss of vision in his right eye were caused by the negligence of all three defendants, and also by Dr Hari and Dr Namazie as servants or agents of the hospital. The High Court allowed the plaintiff's claim and held all three defendants liable. The judicial commissioner ('JC') found that Dr Hari and Dr Namazie were negligent in failing to warn the plaintiff of the risks of bucking and blindness, and in the care and management of the plaintiff. On the issue of vicarious liability, the High Court found the hospital liable for the negligence of Dr Hari and Dr Namazie, as internal arrangements between Dr Hari and Dr Namazie with the hospital were exclusively within their knowledge, and that the hospital had allowed the former two to hold themselves out as the hospital's agents, servants or employees. Accordingly, the plaintiff was awarded: (a) RM200,000 as general damages; (b) RM1m as aggravated damages; and (c) RM8,014 as special damages. The Court of Appeal affirmed the decision of the High Court and held that Dr Hari had wrongly advised the plaintiff to undergo the second operation, thereby subjecting the plaintiff to unnecessary risks including the instance of bucking which led to blindness in the plaintiff's right eye and that Dr Namazie had failed in his responsibility to keep the plaintiff anaesthetised completely, relaxed and pain free throughout the operation. The Court of Appeal also found that the hospital was vicariously liable for the actions of Dr Hari and Dr Namazie and relied on the doctrine of non-delegable duties, by which employers of independent contracts were strictly liable for the contractors' negligence. Hence, two appeals arose against the decision of the Court of Appeal.

**Held,** dismissing appeals with costs:

(1) The case of *Rogers v Whitaker*, which was followed in *Foo Fio Na*, in regard to the standard of care in medical negligence, was restricted only to the duty to advise of risks associated with any proposed treatment; it does not extend to diagnosis and treatment. With regard to the standard of care for diagnosis and treatment, the *Bolam* test still applies subject to qualifications as stated in *Bolitho*. The *Bolam* test is essentially a 'doctor knows best' test. As long as there are two conflicting views on the acceptable medical practice, and the defendant doctor acted based on one of the conflicting views, he would be exonerated from liability. In short, the standard of care is decided by the medical profession. The *Bolitho* test is the extension of the *Bolam* test, which calls upon the court to analyse the logic and reasonableness of the conflicting medical opinion advanced by the defence before accepting the same (see paras 61–63).

(2) The duty to explain risks is specific in nature; the consent form, signed by the plaintiff prior to the operation and relied upon by Dr Hari and Dr Namazie, only contained general precautions that the operation involved risks. Neither Dr Hari nor Dr Namazie had warned the plaintiff of the risks of bucking and blindness at any material time. A reasonable

person in the patient's position would be likely to attach significance to it. In relation to this particular patient, given that the plaintiff had previously requested for scans to be conducted and enquired on the need for the operation, it was apparent that the plaintiff would attach significance to warnings of such risks. As such, such risks were considered to be material risks in the second operation. The duty had been breached by Dr Hari and Dr Namazie. They were therefore negligent and had deprived the plaintiff of the chance to make an informed decision as to whether to proceed with the operation or otherwise (see paras 73–74 & 76).

(3) Contemporaneous documents and testimonies of witnesses showed that there was no retinal detachment. Dr Hari failed to establish that he had acted in accordance with a practice accepted as proper and responsible by a responsible body of medical practitioners skilled in that particular art, in diagnosing that the plaintiff's condition required the second operation. Thus, the *Bolam* test was not satisfied and accordingly, Dr Hari was negligent when he subjected the plaintiff to an unnecessary operation, which ultimately caused the plaintiff to lose his eyesight. Dr Hari also failed to produce any evidence to show that the procedure he adopted when the SCH occurred was in accordance with the practice accepted by a responsible body of medical practitioners. As such, the *Bolam* test was not satisfied on the facts and Dr Hari was negligent in the choice of procedure adopted in treating the plaintiff (see paras 78 & 81).

(4) Dr Namazie was negligent in failing to keep the plaintiff anaesthetised completely during the second operation. Applying the *Bolam* test, Dr Namazie did not produce any evidence to show that his failure to ensure that the plaintiff did not buck during the second operation was supported by a body of responsible medical opinion. The plaintiff had bucked during the second operation because the plaintiff was not anaesthetised completely. The bucking could have been avoided and controlled by additional drugs. In view of the evidence, the top up dose administered on the plaintiff was clearly mistimed. Therefore, the doctors' appeal on liability was dismissed. Applying the relevant tests as clarified in the case of *Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors*, both Dr Hari and Dr Namazie were negligent in their advice of risks, diagnosis and treatment of the plaintiff (see paras 82 & 84–85).

(5) Aggravated damages could and had been awarded as a separate head of damage in tort. Aggravated damages are frequently awarded in defamation cases for injury to a person's reputation; hence there was no reason to exclude this kind of damages from medical negligence cases, which involve real injury to a person's body. In the circumstances, the

second question was answered in the negative. As such, the doctors' appeal on quantum was dismissed (see para 99).

(6) The law on vicarious liability and non-delegable duty is an ongoing development. This court took heed of the proviso in *Woodland* to 'proceed with caution, incrementally by analogy with existing categories, and consistently with some underlying principle' and to impose liability 'only in so far as it would be fair, just and reasonable'. To make a broad announcement on the liability of all private hospitals in medical negligence cases on the basis of policy alone would risk over-generalising the nuances of modern business relationships, and result in an unprincipled approach to liability (see para 142).

**[Bahasa Malaysia summary**

Plaintif mengalami koyakan retina dengan penanggalan pada mata kanannya dan merujuk pada perayu pertama ('Dr Hari') di klinik swastanya. Dr Hari menasihatkan plaintif menjalani pembedahan penanggalan retina secepat mungkin, dan melakukan pembedahan ('pembedahan pertama') atas plaintif di responden kedua ('hospital'). Plaintif kemudian mengadu sakit berterusan dan tekanan yang kuat pada matanya. Apabila pemeriksaan fizikal dan visual dilakukan, Dr Hari memaklumkan plaintif bahawa retina mata kanannya terlipat keluar dan pembedahan kedua harus dijalankan serta merta untuk memperbaikinya disebabkan keadaan yang terdesak. Plaintif meminta satu imbasan dilakukan untuk mengesahkan dapatan tetapi diberitahu Dr Hari bahawa tiada keperluan berbuat demikian. Plaintif pada mulanya meminta perkhidmatan anestetik Dr Manavalan, anestetik untuk pembedahan pertama, tetapi Dr Hari memberi jaminan bahawa anestetik yang bertugas iaitu perayu kedua ('Dr Namazie') sama kompeten. Pembedahan kedua dijalankan dan apabila plaintif sedar semula, dia dimaklumkan bahawa beberapa masalah telah berlaku semasa pembedahan kedua: plaintif tersedar semasa pembedahan dan melambung semasa Dr Hari dalam proses memperkuatkan retina menggunakan laser. Akibatnya, plaintif mengalami Supra-Choroidal Haemorrhage ('SCH'), satu pendarahan berlebihan dalam mata kanannya dan kehilangan penglihatan mata kanan sepenuhnya. Dalam satu laporan perubatan, Dr Hari mengesahkan mata kanan plaintif buta secara kekal akibat penanggalan retina. Plaintif memfailkan guaman sivil terhadap Dr Hari, Dr Namazie dan hospital, dengan dakwaan bahawa kecederaan dan kehilangan penglihatan mata kanannya disebabkan kecuaian ketiga-tiga defendan, dan juga oleh Dr Hari dan Dr Namazie sebagai pekerja-pekerja atau ejen-ejen hospital. Mahkamah Tinggi membenarkan tuntutan plaintif dan memutuskan ketiga-tiga defendan bertanggungjawab. Pesuruhjaya kehakiman ('PK') mendapati bahawa Dr Hari dan Dr Namazie cuai dalam kegagalan mereka untuk memaklumkan kepada plaintif risiko-risiko melambung dan kebutaan, dan dalam penjagaan dan pengurusan plaintif. Berkenaan isu liabiliti ganti rugi, Mahkamah Tinggi mendapati hospital bertanggungjawab atas kecuaian

A Dr Hari dan Dr Namazie, kerana pengurusan dalaman antara Dr Hari dan Dr Namazie dengan hospital adalah secara eksklusif dalam pengetahuan mereka, dan bahawa hospital membenarkan kedua-dua Dr Hari dan Dr Namazie mewakilkan diri mereka sebagai ejen-ejen dan pekerja-pekerja hospital. Oleh itu, plaintif diawardkan: (a) RM200,000 sebagai ganti rugi am; B (b) RM1 juta sebagai ganti rugi teruk; dan (c) RM8,014 sebagai ganti rugi khas. Mahkamah Rayuan mengesahkan keputusan Mahkamah Tinggi dan memutuskan bahawa nasihat yang diberikan oleh Dr Hari untuk plaintif menjalankan pembedahan kedua adalah salah, dengan itu plaintif tertakluk pada risiko-risiko yang tidak perlu termasuk kejadian melambung yang C mengakibatkan mata kanan plaintif buta dan Dr Namazie telah gagal dalam tanggungjawabnya untuk memastikan plaintif dianestetik secara penuh, dan dalam keadaan tenang dan tiada kesakitan sepanjang pembedahan. Mahkamah Rayuan juga mendapati hospital bertanggungjawab secara vikarius bagi tindakan-tindakan Dr Hari dan Dr Namazie dan bergantung pada doktrin D kewajipan tidak boleh diwakilkan, di mana majikan kontraktor bebas bertanggungjawab untuk kecuaian kontraktor-kontraktor itu. Oleh itu, dua rayuan ini.

**Diputuskan,** menolak rayuan-rayuan dengan kos:

E (1) Kes *Rogers v Whitaker*, yang diikuti dalam *Foo Fio Na*, berkenaan standard penjagaan dalam kecuaian perubatan, hanya terhad pada kewajipan untuk memberi nasihat berkenaan risiko-risiko dikaitkan dengan mana-mana rawatan yang dicadangkan; ia tidak meliputi F diagnosis dan rawatan. Berkenaan standard penjagaan diagnosis dan rawatan, ujian *Bolam* masih diguna pakai tertakluk pada kelayakan seperti yang dinyatakan dalam *Bolitho*. Ujian *Bolam* pada dasarnya ujian 'doctor knows best'. Selagi terdapat dua pandangan bertentangan berkenaan amalan perubatan yang boleh diterima, dan doktor selaku G defendan bertindak berdasarkan salah satu daripada pandangan yang bertentangan, dia akan dilepaskan daripada liabiliti. Secara ringkas, standard penjagaan diputuskan oleh profesion perubatan. Ujian *Bolitho* adalah lanjutan ujian *Bolam*, yang menyeru mahkamah menganalisa logik dan kewajaran pendapat perubatan yang bercanggah yang H diberikan oleh pembelaan sebelum menerima yang sama (lihat perenggan 61–63).

(2) Kewajipan menjelaskan risiko-risiko adalah bersifat khusus: borang kebenaran, yang ditandatangani oleh plaintif sebelum pembedahan dan dirujuk oleh Dr Hani dan Dr Namazie, hanya mengandungi langkah I berjaga-jaga umum bahawa pembedahan melibatkan risiko-risiko. Kedua-dua Dr Hari dan Dr Namazie tidak memberikan amaran kepada plaintif berkenaan risiko-risiko melambung dan kebutaan pada setiap waktu material. Seorang yang munasabah dalam kedudukan pesakit berkemungkinan akan mendapati itu penting kepadanya. Berhubungan

pesakit ini, memandangkan plaintif telah sebelum ini meminta imbasan dijalankan dan menyoal keperluan pembedahan ini, jelas bahawa plaintif akan menganggap amaran-amaran yang diberikan mengenai risiko-risiko amat penting. Oleh itu, risiko-risiko itu diambil kira sebagai risiko-risiko penting dalam pembedahan kedua. Kewajipan telah dilanggar oleh Dr Hari dan Dr Namazie. Mereka dengan itu cuai dan telah menafikan plaintif peluang untuk mencapai keputusan yang betul sama ada untuk meneruskan dengan pembedahan atau tidak (lihat perenggan 73–74 & 76).

(3) Dokumen-dokumen semasa dan testimoni saksi-saksi menunjukkan tiada penanggalan retina. Dr Hari gagal membuktikan bahawa dia telah bertindak mengikut amalan yang diterima sebagai sesuai dan bertanggungjawab oleh perbadanan bertanggungjawab pengamal-pengamal perubatan yang mahir dalam seni tertentu itu, dalam mendiagnosis bahawa plaintif memerlukan pembedahan kedua. Oleh itu, ujian *Bolam* tidak dipenuhi dan Dr Hari didapati cuai apabila dia menjalankan pembedahan yang tidak diperlukan ke atas plaintif yang mengakibatkan plaintif hilang penglihatan. Dr Hari juga gagal mengemukakan keterangan menunjukkan bahawa prosedur yang digunakannya semasa SCH berlaku adalah menurut amalan yang diterima oleh perbadanan pengamal-pengamal perubatan. Oleh itu, ujian *Bolam* tidak dipenuhi atas fakta dan Dr Hari cuai dalam memilih menggunakan prosedur tersebut untuk merawat plaintif (lihat perenggan 78 & 81).

(4) Berkenaan rawatan Dr Namazie atas plaintif, anestetik cuai dalam kegagalannya untuk memastikan plaintif dianestetik sepenuhnya semasa pembedahan kedua. Mengguna pakai ujian *Bolam*, Dr Namazie tidak mengemukakan apa-apa keterangan bagi menunjukkan bahawa kegagalannya memastikan plaintif tidak melambung semasa pembedahan kedua disokong oleh badan yang mempunyai pendapat perubatan yang bertanggungjawab. Plaintif telah melambung semasa pembedahan kedua kerana plaintif tidak dianestetik sepenuhnya. Perlambungan mungkin boleh dielakkan dan dikawal oleh ubat tambahan. Mengikut keterangan, dos yang diberikan plaintif dengan jelasnya telah tersalah masa. Oleh itu, rayuan doktor-doktor berkenaan liabiliti ditolak. Mengguna pakai ujian-ujian relevan seperti yang dinyatakan dalam kes *Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors*, kedua-dua Dr Hari dan Dr Namazie cuai dalam memberikan nasihat berkenaan risiko, diagnosis dan rawatan plaintif (lihat perenggan 82 & 84–85).

(5) Ganti rugi teruk boleh dan telah diawardkan sebagai ganti rugi berasingan dalam tort. Ganti rugi teruk sering kali diawardkan dalam kes fitnah kerana mencalar reputasi seseorang; dengan itu tiada alasan untuk

mengecualikan ganti rugi sebegini dari kes kecuaian perubatan, yang melibatkan kecederaan sebenar kepada badan seseorang. Dalam keadaan ini, soalan kedua dijawab secara negatif (lihat perenggan 99).

(6) Undang-undang berkenaan liabiliti secara vikarius dan tanggungjawab tidak boleh diwakilkan adalah perkembangan berterusan. Mahkamah ini mengambil kira proviso dalam kes *Woodland* untuk 'meneruskan dengan berhati-hati, secara berperingkat oleh analogi dengan kategori-kategori yang sedia ada, dan secara konsisten dengan beberapa prinsip asas' dan untuk mengenakan liabiliti 'hanya setakat ia adil, saksama dan munasabah'. Untuk membuat pengumuman secara meluas mengenai liabiliti semua hospital swasta dalam kecuaian perubatan berdasarkan polisi sahaja akan mempunyai risiko tinggi generalisasi nuansa hubungan perniagaan moden, dan mengakibatkan pendekatan yang tiada prinsip terhadap liabiliti (lihat perenggan 142).]

**Notes**

For cases on medical negligence, see 12(1) *Mallal's Digest* (5th Ed, 2017 Reissue) paras 1657–1676.

**Cases referred to**

*Abdul Kadir bin Mohamad v Kamarulzaman bin Mohd Zin & Anor* [2000] MLJU 658; [2001] 5 CLJ 249, HC (refd)
*AT and others v Dulghieru and another* [2009] EWHC 225 (QB), QBD (refd)
*Balasingham v PP* [1959] 1 MLJ 193 (refd)
*Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, QBD (folld)
*Bolitho (administratrix of the estate of Bolitho (deceased)) v City and Hackney Health Authority* [1997] 4 All ER 771, HL (refd)
*Cassidy v Ministry of Health* [1951] 2 KB 343, CA (refd)
*Chia Yan Tek & Anor v Ng Swee Kiat & Anor* [2001] 4 MLJ 1, FC (distd)
*Cox v Ministry of Justice* [2016] AC 660, SC (refd)
*Dr Kok Choong Seng & Anor v Soo Cheng Lin and another appeal* [2018] 1 MLJ 685, FC (folld)
*Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593, FC (folld)
*Ganapathy a/l Rengasamy v PP* [1998] 2 MLJ 577, FC (refd)
*MGG Pillai v Tan Sri Dato' Vincent Tan Chee Yioun* [2002] 2 MLJ 673, FC (refd)
*Martins v Choudhary* [2007] EWCA Civ 1379, CA (refd)
*Mohd Ridzwan bin Abdul Razak v Asmah bt Hj Mohd Nor* [2016] 4 MLJ 282, FC (refd)
*Richardson v Howie* [2004] EWCA Civ 1127, CA (refd)
*Rogers v Whitaker* (1992) 175 CLR 479; [1993] 4 Med LR 79, HC (folld)
*Rowlands v Chief Constable of Merseyside Police* [2006] EWCA Civ 1773, CA (refd)

*Tan Ah Tong v Gee Boon Kee & Ors* [2006] 2 MLJ 618, CA (folld)
*Tan Kim Leng & Anor v Chong Boon Eng & Anor* [1974] 2 MLJ 151, FC (refd)
*The Board of Trustees of the Sabah Foundation & Ors v Datuk Syed Kechik bin Syed Mohamed & Anor* [2008] 5 MLJ 469, FC (refd)
*Udham Singh v Indar Kaur* [1971] 2 MLJ 263, FC (refd)
*Various Claimants v Catholic Child Welfare Society and others* [2013] 2 AC 1, SC (refd)
*Woodland v Swimming Teachers Association and others* [2014] AC 537, SC (folld)
*Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors* [2017] 5 MLJ 438, FC (folld)

**Legislation referred to**

Courts of Judicature Act 1964 ss 38, 42, 42(1), 78, 78(1), 100, 100(2), 101
Medical Act 1971
Private Healthcare Facilities And Services Act 1998
Rules of the Federal Court 1995 rr 6, 64

**Appeal from:** Civil Appeal Nos W-02–2752 of 2010 and W-02–2824 of 2010 (Court of Appeal, Putrajaya)

*PS Ranjan (MS Dhillon, KB Karthi and Rama Tharini with him) (PS Ranjan & Co) in Civil Appeal No 02–21–03 of 2015(W) for the appellants.*
*Kanaga (Vinod Ramasamy with him) (Kanaga, Suresh & Co) in Civil Appeal No 02–26–04 of 2015(W) for the appellant.*
*Leong Wai Hong (Claudia Cheah and Wong Juen Vei with him) (Skrine) in Civil Appeal Nos 02–21–03 of 2015 and 02–26–04 of 2015(W) for the first respondent.*
*Kanaga (Vinod Ramasamy with him) (Kanaga, Suresh & Co) in Civil Appeal No 02–21–03 of 2015(W) for the second respondent.*
*PS Ranjan (MS Dhillon, KB Karthi and Rama Tharini with him) (PS Ranjan & Co) in Civil Appeal No 02–26–04 of 2015(W) for the second and third respondents.*
*Cecil Abraham (JJ Chan, Sunil Abraham, Fazleeza Azli and Ellaine Alexander with him) as amicus curie.*

**Raus Sharif Chief Justice (delivering judgment of the court):**

**[1]** These two appeals are against the decision of the Court of Appeal, which affirmed the decision of the High Court in allowing the claim in medical negligence brought by Megat Noor Ishak Megat Ibrahim ('the plaintiff'). The plaintiff's claim was brought against the first defendant, ophthalmologist Dr Hari Krishnan ('Dr Hari'), the second defendant, anaesthetist Dr Mohamed Namazie ('Dr Namazie'), and the third defendant, the Tun

A Hussein Onn National Eye Hospital ('the hospital').

**[2]** Appeal No 02(f)-21–03 of 2015 ('the doctors' appeal') was filed by Dr Hari and Dr Namazie. In the doctors' appeal, this court granted leave for the following two questions:

B

(i) Whether it is the Bolam test or the test in the Australian case of *Rogers v Whitaker* [1993] 4 Med LR 79 which should be applied to the standard of care in medical negligence, following, after the decision of Federal Court in *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593, conflicting decisions of the Court of Appeal of Malaysia, conflicting decisions of the High Court in Malaysia, and the legislative changes in Australia, including the re-introduction there of a modified *Bolam* test; and

C

(ii) Whether aggravating factors should be compensated for as general damages, therefore rendering a separate award of aggravated damages unnecessary, as decided by the English Court of Appeal in *Richardson v Howie* [2004] EWCA Civ 1127 and explained in *Michael Jones' Medical Negligence* (4th Ed, 2008), para 12-011.

D

**[3]** Appeal No 02(f)-26–04 of 2015 ('the hospital's appeal') was filed by the hospital. The sole leave question in the hospital's appeal reads as follows:

E

> Where the doctors are qualified professionals in a private hospital and working as independent contractors by virtue of a contract between the private hospital and the doctor, can the private hospital be held vicariously liable for the sole negligence of the doctors?

F

**[4]** We heard these two appeals together on 17 April 2017, and adjourned the matter for our decision. We now give our decision and the reasons for the same.

G MATERIAL FACTS

**[5]** The plaintiff had a giant retinal tear with detachment in his right eye. In 1999, he first consulted one Dr Selvarajah Sathya, a general practitioner at Kumpulan Klinik Prima Care, who referred him to one Dr Indira Verghese, a
H consultant ophthalmologist at Subang Jaya Medical Centre. Dr Indira then referred the plaintiff to Dr Hari.

**[6]** On 26 August 1999, the plaintiff consulted Dr Hari at his private clinic, Klinik Pakar Mata Dr Hari, in Medan Tuanku. Dr Hari advised the plaintiff to
I undergo a retinal detachment operation immediately, and performed the operation on the plaintiff at the hospital ('first operation'). The anaesthetist for the first operation was one Dr Manavalan. The plaintiff was discharged on 30 August 1999. An appointment date was fixed for the plaintiff to see Dr Hari in a week's time on 7 September 1999.

**[7]** Subsequently, the plaintiff's right eye became watery, his vision was bullish, and there were tears of blood when he sneezed. The plaintiff immediately telephoned Dr Hari, who assured him that his condition was not alarming and that he need not go to see Dr Hari. Nevertheless on 4 September 1999, the plaintiff went to see Dr Hari on his own accord at the latter's private clinic. By a visual check, Dr Hari confirmed that there was bleeding in the plaintiff's eye and advised the plaintiff to return on the appointment date on 7 September 1999.

**[8]** On 7 September 1999, the plaintiff went to see Dr Hari as scheduled at his private clinic. Dr Hari reassured the plaintiff that there was no concern but that recovery would be slow. The next appointment was scheduled to be at the hospital on 14 September 1999.

**[9]** At the next scheduled appointment at the hospital on 14 September 1999, the plaintiff complained of continuous pain and strong pressure in his eye. Upon a physical and visual inspection, Dr Hari told the plaintiff that the retina of his right eye had folded outward, and that a second operation had to be carried out the same afternoon to repair it due to the urgency of the situation. However, after conducting a scan, Dr Hari informed the plaintiff that his earlier finding of the folded retina and the need for a second operation was incorrect. Another appointment was fixed on 21 September 1999.

**[10]** On 21 September 1999, the plaintiff went to see Dr Hari at the hospital. After examining the plaintiff, Dr Hari informed the plaintiff that the retina in his right eye had folded or partially detached, and recommended a second operation to be carried out that same afternoon. The plaintiff requested for a scan to confirm the findings because he felt that his vision had improved. However, Dr Hari told the plaintiff that a scan was unnecessary because he could verify the condition by physical inspection, and informed the plaintiff that the improved vision was only temporary and may subsequently worsen.

**[11]** The plaintiff was admitted to the hospital at 12 noon on the same day for the operation, which was fixed at 2pm ('second operation'). The plaintiff initially requested for the anaesthetic services of Dr Manavalan, but Dr Hari assured him that the anaesthetist on duty was equally competent. Dr Namazie was the anaesthetist for the second operation. A sedative was administered by a nurse prior to the operation, which commenced at about 3pm.

**[12]** The plaintiff regained consciousness at about 6.30pm. Dr Hari examined him the next day on 22 September 1999, and informed the plaintiff that some problems had occurred during the second operation: the plaintiff had regained consciousness during the operation and bucked while Dr Hari was strengthening the retina using a laser. As a result, the plaintiff suffered

A Supra-Choroidal Haemorrhage ('SCH'), an extensive haemorrhage with profuse bleeding in his right eye. Nevertheless, Dr Hari assured the plaintiff that he would regain his eyesight provided that the retina remained intact after the bleeding in the eye subsides. Dr Hari did not raise the possibility of the plaintiff's right eye going blind.

B

**[13]** Subsequently, the plaintiff experienced severe pain, continuous bleeding and a total loss of vision in his right eye. Dr Hari advised the plaintiff to stay in the hospital for seven days, and to sit in an upright position at all times so that the blood in his eye could subside.

C

**[14]** On 26 September 1999, the plaintiff was discharged. By a letter on 27 September 1999, Dr Hari referred the plaintiff to one Dr Pall Singh of the hospital for a second opinion on the status of the plaintiff's right eye. It was from reading the letter of referral that the plaintiff discovered that Dr Hari had removed the lens in his right eye during the second operation.

D

**[15]** Dr Pall Singh informed the plaintiff that his retina was badly uprooted with a lot of internal blood clotting, and was of the opinion that Dr Hari's suggestion to wash the front part of the eyes would be futile. On 1 October 1999, the plaintiff went back to consult Dr Hari. The plaintiff was told that there was still bleeding in his eye and that a procedure was advised to be performed. Dr Hari then referred the plaintiff to one Dr Seshan Lim of the Lions Eye Centre. Upon examining the plaintiff, Dr Seshan Lim was of the opinion that the plaintiff's right eye was beyond saving.

E

F

**[16]** On the advice of Dr Pall Singh, the plaintiff consulted one Dr Ong Sze Guan of the Singapore National Eye Centre. Dr Ong told the plaintiff that the latter's right eye was badly damaged, having been drenched in blood for more than 25 days. On 15 October 1999, on Dr Ong's recommendation, the plaintiff underwent a surgical procedure, which included the patching of the retina and the removal of blood clots, in an attempt to salvage his vision. The efforts were unsuccessful.

G

H

**[17]** In a medical report dated 24 November 1999, Dr Hari confirmed that the plaintiff's right eye is permanently blind due to retinal detachment, and that his left eye needs prolonged follow up treatment.

I

**[18]** The plaintiff filed a civil suit against Dr Hari, Dr Namazie and the hospital. The plaintiff alleged that the injuries and loss of vision in his right eye were caused by the negligence of all three defendants, and also by Dr Hari and Dr Namazie as servants or agents of the hospital.

DECISION OF THE HIGH COURT

**[19]** The High Court allowed the plaintiff's claim and held all three defendants liable. The learned judicial commissioner ('JC') found Dr Hari and Dr Namazie negligent in failing to warn the plaintiff of the risks of bucking and blindness, and in the care and management of the plaintiff. In doing so, the learned JC expressed her agreement with the submissions by counsel for the plaintiff.

**[20]** On the issue of vicarious liability, the High Court found the hospital liable for the negligence of Dr Hari and Dr Namazie. The learned JC held that the internal arrangements between Dr Hari and Dr Namazie with the hospital were exclusively within their knowledge, and that the hospital had allowed the former two to hold themselves out as the hospital's agents, servants or employees.

**[21]** Accordingly, the learned JC awarded damages to the plaintiff as follows:

(a) RM200,000 as general damages;

(b) RM1m as aggravated damages; and

(c) RM8,014 as special damages.

DECISION OF THE COURT OF APPEAL

**[22]** Dissatisfied, Dr Hari and Dr Namazie filed an appeal against the High Court decision, and the Hospital filed another appeal against the same. The Court of Appeal affirmed the decision of the High Court. Due to the non-speaking judgment of the High Court, which will be elaborated later in this judgment, the Court of Appeal made its own findings of fact.

**[23]** In respect of Dr Hari, the Court of Appeal held that Dr Hari was negligent in his care and management of the plaintiff in the second operation. The Court of Appeal found no evidence that either Dr Hari or Dr Namazie had explained the risk of bucking to the plaintiff at any material time. Dr Hari was held to have wrongly advised the plaintiff to undergo the second operation, and thereby subjected the plaintiff to unnecessary risks including the instance of bucking which led to blindness in the plaintiff's right eye. Further, the procedure adopted by Dr Hari after the haemorrhaging occurred was found to be against all textbook and established clinical teachings.

**[24]** In respect of Dr Namazie, the Court of Appeal concluded that Dr Namazie failed to explain the risk of bucking, based on the fact that the plaintiff had never met Dr Namazie nor been interviewed of his medical

history prior to the administration of the anaesthetic. As an anaesthetist, Dr Namazie failed in his responsibility to keep the plaintiff anaesthetised completely, relaxed, and pain-free throughout the operation. It was found that bucking could have been avoided and controlled by additional drugs. The Court of Appeal considered the fact that the muscle relaxant drug wore off as a clear indication of negligence, and held that there was clear mistiming of the top-up dose.

**[25]** On the issue of vicarious liability, the Court of Appeal explained that hospitals are institutions that provide medical treatment to patients, and patients present themselves at a hospital to seek treatment from that hospital. In view of the inextricable relationship between hospitals and doctors, the hospital's liability for the negligence of Dr Hari and Dr Namazie are not absolved by pure internal arrangements.

**[26]** The Court of Appeal disagreed with the proposition that the hospital cannot be vicariously liable for the actions of independent contractors such as Dr Hari and Dr Namazie. Relying on the doctrine of non-delegable duties, by which employers of independent contractors are strictly liable for the contractors' negligence, the Court of Appeal explained:

> In our view in the admission of a patient, a hospital must be regarded as giving an undertaking that it would take reasonable care to provide for his medical needs. There is an overriding and continuing duty upon hospital as an organisation, to provide the services to its patients. The hospital cannot be mere custodial institution to provide a place where medical personnel meet and treat patients (see *Ellis v Wallsend District Hospital* [1989] 17 NSWLR 553).

**[27]** The Court of Appeal took note of the following facts: the plaintiff's fees were paid to the hospital; the hospital held out Dr Hari as a doctor of the hospital; the plaintiff did not have a choice as to the anaesthetist, since Dr Namazie was the only one on duty at the material time; and the hospital provided all the facilities, drugs and nurses for the operation. Based on these factors, the High Court's finding of vicarious liability on the part of the hospital was affirmed.

**[28]** On the issue of damages, the Court of Appeal took into account the plaintiff's severe pain, loss of vision, nervous shock and distress, embarrassment and humiliation, deprivation of ordinary life experience, and lost promotion prospects. The Court of Appeal saw no reason to disturb the award of damages.

## PRELIMINARY ISSUES AT THE FEDERAL COURT

**[29]** At the outset, learned counsel for Dr Hari and Dr Namazie raised two preliminary issues, namely that:

(a) the judgment of the learned JC was a non-speaking judgment; and

(b) the judgment of the Court of Appeal was not valid.

**[30]** On the first issue, the complaint raised by learned counsel was that, following a long trial and after reserving judgment, the learned JC produced a non-speaking judgment. To appreciate the grievances of learned counsel, we reproduce the full grounds of judgment by the learned JC:

> Based on the evidence of the plaintiff, first defendant, second defendant, the expert witnesses as well as the textbook authorities, I am of the view that the blindness in the plaintiff's right eye was caused by SCH and SCH was caused by bucking. This can be seen from the evidence of the first defendant, both eyes experts (ie SP4 and SD4) and the contemporaneous documents).
>
> As to whether the first defendant and second defendant were negligent, I find both of them have breached the duty of care when they failed to warn the risk of bucking and blindness to the plaintiff. I find both of them were negligent in the care and management of the plaintiff since I am in agreement with submission of learned counsel for the plaintiff as can be seen at pp 21–59 and also at pp 7–9 of the written submission.
>
> As to whether the third defendant is vicariously liable, I am of the view that the internal arrangement between first defendant and second defendant with third defendant were exclusively within their knowledge. During the hearing ample evidence have been adduced showing the third defendant has allowed first defendant and second defendant to hold themselves out as agents or servants/employees of third defendant. Thus, third defendant is vicariously liable for actions of first defendant and second defendant.
>
> Accordingly the plaintiff's claim against the defendants is allowed with costs and interests.
>
> *Quantum*
>
> General damages — a sum of RM200,000 is a reasonable amount in the circumstances of this case to be awarded to the plaintiff.
>
> Aggravated damages — based on the factors stated in the plaintiff's written submission a sum of RM1m is awarded.
>
> Special damages — the amount to be paid to the plaintiff is the sum in respect of which the defendants have not disputed as seen from the notes of evidence recorded by Mohd Hishamudin J.

**[31]** On the second issue, learned counsel pointed out that the written judgment of the Court of Appeal was issued by a single judge, for two of the judges on the panel concerned have already retired at the time. In addition, the written judgment was dated 1 September 2015 and issued after a significant period of delay following the pronouncement of the Court of Appeal decision on 24 April 2014. It was contended that the judgment of the Court of Appeal fell foul of ss 38 and 42 of the Courts of Judicature Act 1964 ('the CJA') as well

as r 6 of the Rules of the Federal Court 1995, and is therefore null and void. Counsel submitted that a grievous miscarriage of justice had been occasioned in the circumstances, and urged that a retrial or a re-hearing of the appeal by another panel of the Court of Appeal be ordered.

**[32]** In reply, learned counsel for the plaintiff submitted that the two complaints raised by counsel for Dr Hari and Dr Namazie should be disregarded, given that they did not obtain leave of this court to submit on those two issues. In any event, it was submitted that the decision of the learned JC was entirely correct, based on the documentary and oral evidence adduced by the parties.

**[33]** In respect of the second complaint, learned counsel for the plaintiff submitted that the events in the Court of Appeal do not support the doctors' contention. It was highlighted that when the decision of the Court of Appeal was pronounced in open court on 24 April 2014, it was in the presence of all three members of the panel. Thus, that judgment of the Court of Appeal was not a nullity.

**[34]** We agree that the two preliminary issues raised by learned counsel for the Dr Hari and Dr Namazie were issues on which leave to appeal was not obtained. Nevertheless, we would like to state our views on the two issues as guidance for the courts below when confronted with these issues. We will deal with each of the two issues briefly below.

*Non-speaking judgment of the High Court*

**[35]** In order to determine whether a judgment is a speaking judgment, one has to look into its contents and decide whether it has sufficient coverage of material facts to enable one to determine the legal issues, with reference to the crucial arguments for and against as raised by the parties.

**[36]** In *Tan Kim Leng & Anor v Chong Boon Eng & Anor* [1974] 2 MLJ 151, Raja Azlan Shah FJ (as His Royal Highness then was) emphasised the importance of a reasoned judgment as follows:

> In reaching a conclusion the learned judge had to consider the probabilities and the circumstances of the whole case. It was essentially a case in which *there should have been a full record of the reasons which persuaded him to reach the conclusion he did. A mere finding of no negligence against both the respondents and that the accident occurred because of the sudden brake failure on account of some latent defect in the braking system, not supported by reasons, is not a judgment according to law.*
>
> A judicial determination of a dispute where substantial questions of mixed fact and law arise is satisfactorily reached only if it be supported by the most cogent reasons

that commend themselves to the learned judge. Recording of reasons in support of a decision of a dispute serves more purposes than one. It is intended to ensure that the decision is not the result of whim or fancy. 'It is of course true', said Sir Alfred Denning (as he then was), 'that his decision may be correct even though he should give no reason for it or even give a wrong reason: but, in order that a trial should be fair, it is necessary, not only that a correct decision should be reached, but also that it should be seen to be based on reason; and that can only be seen, if the judge himself states his reasons'. See *The Road to Justice*, p 29.

A party to the dispute is ordinarily entitled to know the grounds on which the learned judge has decided against him, and more so, when the judgment is subject to appeal. An appellate court will then have adequate material on which it may determine whether the facts are properly ascertained, the law has been correctly applied and the resultant decision is just. (Emphasis added.)

**[37]** The importance of a speaking judgment cannot be over-stressed (see *Balasingham v Public Prosecutor* [1959] 1 MLJ 193 and *Ganapathy a/l Rengasamy v Public Prosecutor* [1998] 2 MLJ 577). In the instant case, the issue of the non-speaking judgment by the learned JC was addressed by the Court of Appeal in the following manner:

We agree with learned counsel for the defendants that the judgment of the learned JC was indeed a non-speaking judgment. However, there is no law that can allow an appeal simply because the judgment of the lower court was a non-speaking judgment. No doubt we do not condone such practice by the learned JC. We take the view that it is the duty of a trial judge to state clearly in her judgment the facts of the case as adduced by evidence, the legal issues requiring determination as well as the application of the laws to the facts and how the learned trial judge reached a conclusion on the findings of fact and law. Then it is for the appellate court to determine whether or not the learned trial judge had committed any error in the findings and application of laws to those facts.

The failure of the trial judge to carefully state her reasons and findings would create enormous difficulties at the appellate stage. It would entail the appellate court to sieve through the appeal records and peruse the notes to see if there are sufficiently supportive of the decision and findings of the trial judge or otherwise.

Indeed the appellate court would not simply interfere with those findings unless they are erroneous. Upon our perusal of the appeal records before us, we agree with the findings of the learned JC and her award of damages for the reasons we elaborate below.

**[38]** We endorse the view of the Court of Appeal quoted above, and agree that the High Court judgment in the instant case was a non-speaking one. Nevertheless, as will be elaborated below, it does not follow that a retrial or a rehearing should be ordered.

*No valid judgment of the Court of Appeal*

**[39]** The sequence of events before the Court of Appeal is as follows. Both the doctors' appeal and the hospital's appeal were heard by the Court of Appeal on 22 April 2014, before a panel comprised of Linton Albert JCA, Mah Weng Kwai JCA and Rohana Yusof JCA. Having perused the written submissions and heard the oral submissions by counsel, the panel reserved judgment until 24 April 2014. On the given date, the doctor's appeal and the hospital's appeal were unanimously dismissed, and the decision was delivered in open court in the presence of the three panel members, all of whom were still in office.

**[40]** Leave to appeal was granted by this court on 17 March 2015, by which time Linton Albert JCA and Mah Weng Kwai JCA have retired. The Court of Appeal's written grounds of judgment was released on 1 September 2015 by Rohana Yusof JCA.

**[41]** Learned counsel for the doctors submitted that in these circumstances, the judgment was in contravention of ss 38 and 42 of the CJA, which provide as follows:

> 38 Composition of the Court of Appeal
>
> (1) Subject as hereinafter provided, *every proceeding in the Court of Appeal shall be heard and disposed of by three Judges* or such greater uneven number of Judges as the President may in any particular case determine.
>
> (2) In the absence of the President the senior member of the Court shall preside.
>
> 42 Continuation of proceedings notwithstanding absence of Judge
>
> (1) If, *in the course of any proceeding, or, in the case of a reserved judgment*, at any time before delivery of the judgment, any Judge of the Court hearing the proceeding is unable, through illness or any other cause, to attend the proceeding or otherwise exercise his functions as a Judge of that Court, the hearing of the proceeding shall continue before, and judgment or reserved judgment, as the case may be, shall be given by, the remaining Judges of the Court, not being less than two, and the Court shall, for the purposes of the proceeding, be deemed to be duly constituted notwithstanding the absence or inability to act of the Judge as aforesaid.
>
> (2) In any such case as is mentioned in subsection (1) the proceeding shall be determined in accordance with the opinion of the majority of the remaining Judges of the Court, and, if there is no majority the proceeding shall be re-heard. (Emphases added.)

**[42]** Reliance was also placed on r 64 of the Rules of the Federal Court 1995 ('the RFC'), which states:

Rule 64 Certificate of grounds of judgment

On the application of any person who has within the time limited given notice of appeal against any judgment or order, the Court of Appeal shall, unless the judgment was written, certify in writing the grounds of such judgment or order, but delay or failure so to certify shall not prevent the appellant from proceeding with the appeal.

**[43]** We consider that the above sections do not lend assistance to counsel. Since the appeal was heard and disposed of by the three judges on the Court of Appeal panel, the requirements of s 38 above are met. Section 42(1) applies only where any judge of the court is absent 'in the course of any proceeding, or, in the case of a reserved judgment, at any time before delivery of the judgment'. Given that the unanimous judgment of the Court of Appeal had already been delivered orally in open court in the presence of all three judges, the section does not apply in this case.

**[44]** We also note that nothing in r 64 of the RFC lends support to counsel's contention that the Court of Appeal ought to have certified the grounds of judgment without delay, or that all or enough judges on the Court of Appeal panel should be in office at the time of certification. However, r 64 expressly provides that 'delay or failure so to certify shall not prevent the appellant from proceeding with the appeal'.

**[45]** The issue has previously been dealt with by this court in *The Board of Trustees of the Sabah Foundation & Ors v Datuk Syed Kechik bin Syed Mohamed & Anor* [2008] 5 MLJ 469, which concerned substantially similar facts. In that case, in the Court of Appeal, judgment was delivered in open court by way of a unanimous decision in the presence of all three members of the panel. Subsequently, two of the Court of Appeal judges provided their written grounds of judgment. The two judges then retired before their grounds were read in open court. The third judge neither provided his own grounds of judgment, nor communicated his approval for the other judges' grounds of judgment. In the circumstances, this court held that s 42 of the CJA was inapplicable to render the grounds of judgment a nullity:

It is clear that s 42 of the CJA only applies in a situation where before delivery of judgment, any judge of the court hearing the proceeding is unable, through illness or any other cause to attend the proceedings or otherwise exercise his functions as a judge of that court. *It is not the case here wherein all the three member panel of the court were present when the judgment was pronounced in open court*. It is true in this case that the judgment pronounced by the Court of Appeal on 6 June 2003 was without written grounds of judgment and therefore there was no delivery of a reasoned judgment. However, written grounds of judgment were delivered at a later date and hence there was in fact a reasoned judgment given. (Emphasis added.)

**[46]** Two other decisions of this court were cited by learned counsel for Dr Hari and Dr Namazie in support of their contention: *Chia Yan Tek & Anor v Ng Swee Kiat & Anor* [2001] 4 MLJ 1 and *MGG Pillai v Tan Sri Dato' Vincent Tan Chee Yioun* [2002] 2 MLJ 673. *Chia Yan Tek* concerned the application of s 78(1) of the CJA, which is in pari materia with s 42(1), in respect of proceedings in the Federal Court. The case was heard by three judges in the Federal Court, who reserved judgment to another date. On the date that the judgment was pronounced in open court, two of the three judges had retired. Mohamed Dzaiddin CJ held that the effective date of any judgment is the date of its pronouncement in open court, and not any other earlier acts aimed at arriving at a decision. Since the court was not duly constituted on the date that the judgment was pronounced, the judgment was accordingly set aside. The facts in *Chia Yan Tek* are evidently distinguishable: in the present case, there is no doubt that the Court of Appeal was duly constituted on the date that the judgment was pronounced in open court.

**[47]** Similarly in *MGG Pillai*, one of the three judges on the Federal Court panel had retired prior to the pronouncement of the judgment in open court. Based on the current provision of s 78 of the CJA as amended in 1998, the court, comprised of the remaining two judges, could be deemed to be duly constituted. However, the amendment had not yet been made at the time the appeal was filed. The original version of s 78 included a proviso that the appeal shall be re-heard if the parties do not consent to the determination of the proceedings in accordance with the opinion of the majority of the remaining judges. Having found that the amendment was not retrospective, this court held that the consent of the parties was required, and the absence of such consent invalidated the impugned judgment. In the present case, the requirement of consent does not arise.

**[48]** For the above reasons, we find that the Court of Appeal judgment is valid. In view that the Court of Appeal was validly constituted at the time judgment was delivered on the appeal, the fact that two of the three panel members had retired at the time the written grounds of judgment were subsequently given is a non-issue.

*Retrial*

**[49]** The conditions for this court to order a retrial in civil cases is provided in s 100 of the CJA:

> 100 New trial
>
> (1) Except as hereinafter provided, the Federal Court shall have power to order that a new trial be had of any cause or matter tried by the High Court in the exercise of its original or appellate jurisdiction.

(2) *A new trial shall not be granted on the ground of improper admission or rejection of evidence unless in the opinion of the Federal Court some substantial wrong or miscarriage of justice has been thereby occasioned*; and if it appears to the Federal Court that the wrong or miscarriage affects part only of the matters in controversy, or some or one only of the parties, the Federal Court may give final judgment as to part thereof, or as to some or one only of the parties, and direct a new trial as to the other part only, or as to the other party or parties.

(3) ... (Emphasis added.)

**[50]** Section 100(2) of the CJA expressly sets out the limited grounds on which a new trial may be granted. Section 101 of the CJA goes on to provide that immaterial errors are not a valid basis for the court to order a new trial:

101 Immaterial errors

No judgment or order of the High Court, or of any Judge, shall be reversed or substantially varied on appeal, nor a new trial ordered by the Federal Court, on account of any error, defect, or irregularity, whether in the decision or otherwise, not affecting the merits or the jurisdiction of the Court.

**[51]** The combined effect of both sections is to place the burden on the party seeking retrial to satisfy the court that there was some substantial wrong or miscarriage of justice occasioned by the trial court, which has affected the merits or the jurisdiction of the court. For instance, in *Udham Singh v Indar Kaur* [1971] 2 MLJ 263, this court ordered a new trial on the basis of a misdirection by the trial judge. The trial judge had wrongly placed the burden of proving testamentary incapacity, and it was held that the misdirection had occasioned a substantial wrong.

**[52]** The Court of Appeal had an occasion to consider a similar issue in *Tan Ah Tong v Gee Boon Kee & Ors* [2006] 2 MLJ 618. In that case, no grounds of judgment were issued, for the trial judge had retired soon after the decision was delivered. The Court of Appeal declined to grant a new trial on that basis. In the words of Abdul Aziz Mohamad JCA (as he then was):

... Where a judge does not state his reasons for arriving at his decision, the decision is not necessarily unsafe. He may have properly considered and weighed the evidence and may have arrived at the right conclusions. The decision is only unsafe in the sense that the appellate court is unable to determine, from an assessment of the judge's mental processes, that the decision is correct. But it does not follow that the course open to the appellate court to decide the appeal while doing justice is to order a new trial. *It is still open to the appellate court to assess the evidence and come to a finding whether or not the evidence vindicates the decision of the trial judge.*

*Where, in an appeal in a civil matter, as in this appeal, reasons for the decision appealed against are not available, and not obtainable, the appeal, onerous though this may be, should proceed on an examination and assessment of the evidence to enable the appellate*

A *court to decide whether the evidence justifies the decision or otherwise. It will be as if the appellate court is sitting at first instance, except that the evidence is already before it. For reasons that are obvious or can easily be imagined, a new trial is undesirable and ought not to be ordered unless there is something crucial to a just decision in the case that can be established in the new trial but cannot be established on an assessment of the evidence.*
B *The evidence being all there already, such a thing must be very rare indeed.* (Emphasis added.)

**[53]** On this point, we find the lucid remarks of Abdul Aziz Mohamed JCA (as he then was) illuminating and we endorse the passages quoted above.

C

**[54]** In the instant case, the statutory requirements for a retrial have not been established by Dr Hari and Dr Namazie. We do not consider that the non-speaking judgment of the High Court, or the retirement of two panel judges at the time the Court of Appeal issued their written grounds of
D judgment, constitutes a substantial wrong or a miscarriage of justice that affected the merits or jurisdiction of the High Court. Further, we note that the Court of Appeal was able to, and had in fact, proceeded with the appeal and made a determination by considering all the evidence in the records of appeal
E available to them. There was sufficient material for the Court of Appeal to make the relevant findings and reach a decision as if it was sitting in the first instance. For these reasons, a retrial or a rehearing is not warranted.

**[55]** We would like to add that a retrial or a rehearing should not be easily
F ordered. Appellate courts are advised to avoid ordering a retrial, merely on account of a non-speaking judgment by the trial judge or the absence of any finding of fact on a particular issue. In such a situation, it is the duty of the appellate court to endeavour to make its own finding of fact, based on the evidence available in the record of appeal.

G

**[56]** A retrial may be unduly prejudicial to the parties and an unnecessary inconvenience to the witnesses. This is especially so in this case, where the alleged negligence occurred in September 1999, more than 17 years ago. The
H trial commenced in year 2007 and only concluded in year 2010, after a protracted trial spanning 23 days and involving ten witnesses, including seven medical professionals. A retrial would be contrary to the best interests of justice, and is in any event unwarranted in the circumstances of this case.

I **[57]** Having disposed of the preliminary issues, we shall now deal with the main appeals.

THE DOCTORS' APPEAL: FIRST QUESTION

**[58]** The first of two questions posed in the doctors' appeal concerns liability. The question reads:

> Whether it is the *Bolam* test or the test in the Australian case of *Rogers v Whitaker* [1993] 4 Med LR 79 which should be applied to the standard of case in medical negligence, following, after the decision of Federal Court in *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593, conflicting decisions of the Court of Appeal of Malaysia, conflicting decisions in the High Court in Malaysia, and the legislative changes in Australia, including the re-introduction there of a modified *Bolam* test.

**[59]** A similar question was dealt with by this court recently in *Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors* [2017] 5 MLJ 438. The question reads:

> Whether the *Bolam* test or the test in the Australian case of *Rogers v Whitaker* [1993] 4 Med LR 79 in regard to the standard of case in medical negligence should apply, following conflicting decisions of the Court of Appeal in Malaysia and legislative changes in Australia, including the re-introduction there of a modified *Bolam* test.

**[60]** In answering the said question, this court concluded as follows:

> Thus, it is our judgment that in respect of the standard of care in medical negligence cases, a distinction must be made between diagnosis and treatment on the one hand and the duty to advise of risks on the other. This is because diagnosis and treatment are purely in the realm of medicine and that in the field of medicine, there are genuine differences of professional opinion in respect of diagnosis and treatment. Although as a discipline, medicine involves specific knowledge, its practice, however, often does not admit to scientific precision. It is not always the case that there is a definite answer one way or the other. In fact, medical experts do genuinely and frequently differ in opinion on diagnosis and treatment.
>
> Given the fact that there are genuine differences in opinion in diagnosis and treatment, it is therefore not a matter that the court can, or is, equipped to resolve. It is in this context that the *Bolam* test makes good sense. It requires the court to accept, not just the views of medical experts simpliciter, but the views of a responsible body of men skilled in that particular discipline. It removes from the courts the responsibility of resolving a dispute that is not equipped to resolve.
>
> On the other hand, different consideration ought to apply to the duty to advise of risks as opposed to diagnosis and treatment. That duty is said to be noted in the right of self-determination. As decided by the Australian High Court in *Rogers v Whitaker* and followed by this court in *Foo Fio Na*, it is now the courts (rather than a body of respected medical practitioners) which will decide whether a patient has been properly advised of the risks associated with a proposed treatment. The courts would no longer look to what a body of respectable members of the medical profession would do as the yardstick to govern the standard of care expected in respect of the duty to advise.

A Based on the foregoing, we will answer question 1 in the following manner. The test propounded by the Australian case in *Rogers v Whitaker* and followed by this court in *Foo Fio Na* in regard to standard of care in medical negligence is restricted only to the duty to advise of risks associated with any proposed treatment and does not extend to diagnosis or treatment. With regard to the standard of care for diagnosis B or treatment, the *Bolam* test still applies, subject to qualifications as decided by the House of Lords in *Bolitho*.

**[61]** Since the first question in the present doctor's appeal is substantially the same, if not identical, to the question in *Zulhasnimar* quoted above, our answer C to the first question will be the same. We hold that the Australian case, which was followed by this court in *Foo Fio Na* in regard to the standard of care in medical negligence, is restricted only to the duty to advise of risks associated with any proposed treatment; it does not extend to diagnosis and treatment. With regard to the standard of care for diagnosis and treatment, the *Bolam* test D still applies, subject to qualifications as stated by the House of Lords in *Bolitho*.

**[62]** To summarise, the *Bolam* test is essentially a 'doctor knows best' test. As long as there are two conflicting views on the acceptable medical practice, and E the defendant doctor acted based on one of the conflicting views, he will be exonerated from liability. In short, the standard of care is decided by the medical profession.

**[63]** The *Bolitho* test is the extension of the *Bolam* test, which calls upon the F court to analyse the logic and reasonableness of the conflicting medical opinion advanced by the defence before accepting the same. The court should not accept an opinion put forward by the defence as being 'reasonable', 'respectable' or 'responsible' without first assessing whether such opinion is susceptible to logical analysis.

G

**[64]** The *Rogers v Whitaker* test, which was adopted by this court in *Foo Fio Na*, places the defendant doctor on the same footing as other professionals who are sued for negligence. The court may consider expert evidence on what the acceptable medical practice is, but ultimately it is for the courts to adjudicate H on the appropriate standard of care.

**[65]** The question now is whether Dr Hari and Dr Namazie were negligent in the advice, diagnosis and treatment of the plaintiff in respect of the second operation.

I

*Submissions*

**[66]** Learned counsel for Dr Hari and Dr Namazie submitted that the plaintiff's blindness was caused by retinal detachment. It was contended that

the second operation was necessary to re-attach the detached retina, but failed despite Dr Hari's exercise of care and skill. Further, counsel argued that even if the risk had been disclosed to the plaintiff and he had rejected the operation, the eye would still go blind because of the retinal detachment. According to counsel, the second operation was an attempt to save sight but the blindness was inevitable; the plaintiff did not have much choice but to undergo the operation and take the risk.

**[67]** In addition, it was submitted on behalf of the doctors that the finding of negligence against them was made without supporting evidence for the failure to warn the plaintiff of the risks of bucking under anaesthesia during the second operation. The risk of blindness, it was argued, was too remote to be a material risk, whether according to the *Bolam* test or the *Rogers* test. Since only material risks need to be disclosed by a doctor to enable a patient to decide whether or not to accept the risk and undergo the treatment, there was no necessity to disclose it to the plaintiff.

**[68]** Counsel for Dr Hari and Dr Namazie further submitted that the plaintiff was given sufficient muscle relaxant drugs. It was pointed out that plaintiff did not buck during the first operation; given that more drugs were given in the second operation than in the first operation, blindness caused by bucking was not reasonably foreseeable.

**[69]** In response, learned counsel for the plaintiff submitted that Dr Hari and Dr Namazie were negligent in the care and management of the plaintiff, regardless of which test is applied. It was argued that Dr Hari and Dr Namazie failed to adduce evidence to show that their actions were in accordance with any acceptable medical practice in three areas, namely diagnosis, treatment, and the advice and warning of risks.

**[70]** In particular, counsel for the plaintiff contended that Dr Hari was negligent because he wrongly advised the plaintiff to undergo the second operation, which was alleged to be unnecessary. It was further submitted that Dr Hari failed to advise the plaintiff of the risk of blindness and bucking in the second operation. In addition, upon the occurrence of Supra-Choroidal Haemorrhage (SCH), Dr Hari adopted a wrong method in a procedure which further aggravated the condition.

**[71]** With regard to Dr Namazie, it was submitted that the anaesthetist was negligent because he failed to interview the plaintiff prior to the second operation, and following therefrom failing to warn the plaintiff of the risk of bucking in the second operation. It was also argued that Dr Namazie failed to monitor the plaintiff closely during the second operation, thereby resulting in the wearing off of the muscle relaxant drug, which caused the plaintiff to buck.

Counsel relied on expert anaesthetist evidence that the aim of anaesthetists is to avoid bucking, and that bucking can be avoided by monitoring.

*Our decision on the first question*

**[72]** We turn to consider in more detail the findings of the Court of Appeal. On the issue of the doctors' failure to *advise* and warn the plaintiff of the risks of bucking and blindness, the Court of Appeal found that:

> [29] The defendants had suggested to the plaintiff that first defendant had explained the risk of blindness, which was eventually established as being caused solely by the plaintiff bucking during the operation. No evidence was however established that either of the defendants had indeed explained the risk of bucking to the plaintiff at any material time. The fact that the plaintiff never met Dr Namazie, nor been interviewed of his medical history prior to the administration of his anaesthetic would draw a conclusion of failure to explain the risk of bucking by Dr Namazie. In his evidence, the plaintiff said he had never met Dr Namazie which until the day of trial. The plaintiff said he heard the word 'buck' used for the first time by Dr Hari after the second operation.

**[73]** In their analysis, the Court of Appeal referred to the case of *Foo Fio Na*, which applied the *Rogers* test. The Court of Appeal also held that the duty to explain risks is specific in nature; the consent form, signed by the plaintiff prior to the operation and relied upon by Dr Hari and Dr Namazie, only contained general precautions that the operation involves risks.

**[74]** We agree with the Court of Appeal in finding that neither Dr Hari nor Dr Namazie warned the plaintiff of the risks of bucking and blindness at any material time. In the circumstances, a reasonable person in the patient's position would be likely to attach significance to it. We further note that in relation to this particular patient, given that the plaintiff has previously requested for scans to be conducted and enquired on the need for the operation, it is apparent that the plaintiff would attach significance to warnings of such risks. As such, we consider such risks to be material risks in the second operation. Following *Zulhasnimar*, applying the test in *Foo Fio Na* and *Rogers* in relation to the duty to advise of risks associated with any proposed treatment, we find no difficulty in concluding that the duty has been breached by Dr Hari and Dr Namazie.

**[75]** In any event, we note that the evidence in the case supports the characterisation of the risks as material risks which ought to have been conveyed to the plaintiff. Dr Pall Singh ('SD2'), a witness for the doctors, testified that it was a practice in year 1999 to warn patients of the risks of surgery and anaesthesia. SD2 also testified that the first and second operations were operations involving a high risk of blindness. In fact, both the anaesthetic

experts called by the plaintiff (SP5) and by Dr Namazie (SD5) agreed that the risks involved in anaesthesia must be explained to the plaintiff. They also both agreed that a patient must be interviewed when he is fully awake and not under the influence of drugs.

**[76]** We accept the finding of fact that Dr Namazie never interviewed the plaintiff prior to the second operation: the first time the plaintiff met Dr Namazie was on the day of trial, and the first time the plaintiff heard the word 'buck' was after the second operation. Based on the evidence, Dr Hari and Dr Namazie have failed to explain the risks of bucking and blindness to the plaintiff. They were therefore negligent for not doing so, thereby depriving the plaintiff of the chance to make an informed decision as to whether to proceed with the operation or otherwise.

**[77]** On the issue of Dr Hari's *diagnosis* of the plaintiff"s condition and advice for the plaintiff to undergo the unnecessary second operation, the Court of Appeal found Dr Hari negligent:

> [34] The evidence of the expert witness for the plaintiff, Dr Billy Tan (SP4) from Gleneagles Singapore supported the plaintiff's case that Dr Hari had put the plaintiff through the unnecessary second operation and that Dr Hari had not properly diagnosed the plaintiff's problem. There was no need for the second operation according to Dr Billy Tan who stated that the records do not show any retinal detachment to justify the second operation. SD4 (Dr Wong) on the other hand in cross-examination admitted that he could have presumed retinal detachment from the records to support the second operation. The record of Dr Hari confirmed that there was no retinal detachment.

**[78]** Following *Zulhasnimar*, the *Bolam* test as qualified in *Bolitho* is to be applied in respect of diagnosis and treatment. In the present case, both the plaintiff's expert (SP4) and Dr Hari's expert (SD4) agreed that the second operation would only be necessary if there was retinal detachment. As noted by the Court of Appeal in the passage above, the contemporaneous documents and testimonies of witnesses show that there was no retinal detachment. In view thereof, Dr Hari failed to establish that he acted in accordance with a practice accepted as proper and responsible by a responsible body of medical practitioners skilled in that particular art, in diagnosing that the plaintiff's condition required the second operation. It has also not been suggested that the expert evidence in the present case were incapable of withstanding logical analysis. Thus, we are of the view that the *Bolam* test was not satisfied. Accordingly, we find that Dr Hari was negligent when he subjected the plaintiff to an unnecessary operation, which ultimately caused the plaintiff to lose his eyesight.

**[79]** On the issue of Dr Hari's *treatment* of the plaintiff in the choice of

procedure used in the second operation, we are also in agreement with the finding of the Court of Appeal as follows:

> [35] On the procedure and treatment adopted by Dr Hari, Dr Billy Tan explained that the golden principle in managing SCH is to 'close up and get out'. The view on 'close up and get out' method finds support in literature in exh P3 titled, 'Vitreoretinal Disease The Essentials' which states that for intraoperative SCH the surgeon must immediately close all ocular incisions. In another literature on the subject in exh P5, it is stated that the management of SCH consists of immediate closure of the wound. SD4 (Dr Wong) also agreed on the proposition and opined it to be a principle cast in stone and not subject to individual preference.
>
> [36] Dr Hari claimed in his testimony that he had immediately closed up the scleral wounds. However, evidence shows that he waited for five minutes and then proceeded to open up a bigger incision to remove the lens. We further note that this was never the pleaded case of Dr Hari nor was it noted anywhere in the documents.
>
> [37] Though Dr Wong supported the removal of the lens, his view is subjected to the fact that SCH is deemed stable before it should be done and if the SCH is continuing, he agreed that a surgeon should not do cataract extraction. There is no evidence however from SD1 (first defendant) that the SCH had stopped when the lens was removed.
>
> [38] Dr Hari justified removing the lens to prevent a painful blind eye.
>
> [39] Dr Hari had proceeded to do an Extra Capsular Cataract Extraction (ECCE) after the SCH occurred. This is against all textbook and established clinical teachings. When questioned as to why there is no textbook or literature to teach surgeons or doctors to do cataract surgery to prevent such serious painful conditions, which are allegedly frequently encountered by patients with massive SCH, SD4 (Dr Wong) was evasive and did not answer the question posed.
>
> [40] It is interesting to note that both SD2 (Dr Pall Singh) and SD4 (Dr Wong) testified that Dr Hari had to remove the lens to continue with the operation. This appears to be a new allegation not pleaded by Dr Hari or said by Dr Hari in his testimony. Dr Hari merely said that he removed the lens to prevent painful blind eye, but never say that he removed the lens with a view to continue with the operation.

**[80]** We consider the above findings of the Court of Appeal to be well supported by evidence. It is clear that when the SCH occurred, Dr Hari proceeded to do the Extra Capsular Cataract Extraction ('ECCE'). The plaintiff's expert (SP4) produced several medical literature materials stating that when SCH occurs, the golden principle is to 'close up and get out'. This golden principle was agreed to by Dr Hari's experts, SD2 and SD4. However, SD2 and SD4 both alleged that Dr Hari had to remove the lens to continue with the operation. This is in contrast with Dr Hari's own testimony that he removed the lens to prevent the plaintiff from waking up with a painful blind eye. When cross-examined on whether the prevention of a painful blind eye was a reason to remove the lens, SD2 expressly stated his disagreement.

**[81]** We are of the view that Dr Hari had not produced any evidence to show that the procedure he adopted when the SCH occurred, namely ECCE, was in accordance with the practice accepted by a responsible body of medical practitioners. As such, the *Bolam* test is not satisfied on the facts, and we find Dr Hari negligent in the choice of procedure adopted in treating the plaintiff.

**[82]** In respect of Dr Namazie's *treatment* of the plaintiff, the Court of Appeal also found the anaesthetist negligent in failing to keep the plaintiff anaesthetised completely during the second operation. The Court of Appeal found:

> [48] As an anaesthetist, Dr Namazie agreed that it was his responsibility to keep the plaintiff anaesthetised completely, throughout the operation, relaxed and pain free. It is clearly established that the plaintiff was not anaesthetised completely as he bucked resulting finally in blindness ...
>
> [52] Anaesthetist experts, namely Professor Delikan (SP5) and Dr Das (SD5) agreed that bucking is not acceptable to them as anaesthetists. In fact SP4 (Dr Billy Tan) also testified that bucking is not acceptable to him as a surgeon.

**[83]** The Court of Appeal also found that bucking could clearly have been avoided:

> [51] In our view the very fact that muscle relaxant drug were off is a clear indication of negligence. The fact that the plaintiff did not buck further after top up dose was given shows that the bucking could have been avoided and controlled by additional drugs. In evidence there was clearly mistiming of top up dose since it was not disputed that if a top up had been given earlier ... the plaintiff would not have bucked.

**[84]** Again, we see no reason to disturb the above findings of the Court of Appeal in this regard, with which we are in complete agreement. The pleaded defence that bucking is an unavoidable complication is untenable. Applying the *Bolam* test in this respect, Dr Namazie did not produce any evidence to show that his failure to ensure that the plaintiff did not buck during the second operation was supported by a body of responsible medical opinion. On the facts, the plaintiff bucked during the second operation because the plaintiff was not anaesthetised completely. The bucking could have been avoided and controlled by additional drugs. In view of the evidence, the top up dose administered on the plaintiff was clearly mistimed.

**[85]** We therefore dismiss the doctors' appeal on liability. Based on the foregoing, applying the relevant tests as clarified in *Zulhasnimar*, we find both Dr Hari and Dr Namazie negligent in their advice of risks, diagnosis, and treatment of the plaintiff.

A THE DOCTORS' APPEAL: SECOND QUESTION

**[86]** The second question in the doctors' appeal reads:

> Whether aggravating factors should be compensated for as general damages, therefore rendering a separate award of aggravated damages unnecessary, as decided by the English Court of Appeal in *Richardson v Howie* [2004] EWCA Civ 1127 and explained in *Michael Jones' Medical Negligence* (4th Edn, 2008) para 12-011.

**[87]** It is recalled that the damages awarded by the learned JC and affirmed by the Court of Appeal were as follows:

(a) RM200,000 as general damages;

(b) RM1m as aggravated damages; and

(c) RM8,014 as special damages.

*Submissions*

**[88]** Learned counsel for Dr Hari and Dr Namazie raised two main contentions. First, the award of damages was manifestly excessive and contrary to legal principle. According to counsel, comparable cases like *Abdul Kadir bin Mohamad v Kamarulzaman bin Mohd Zin & Anor* [2000] MLJU 658; [2001] 5 CLJ 249 do not show an award beyond the sum of RM70,000 for pain and suffering and loss of amenities of life for a blind eye. For blindness in one eye, the Bar Council's Revised Compendium of Personal Injury Awards gave a range of only RM77,000–RM82,500 for general damages, which is below the sum of RM200,000 awarded in this case.

**[89]** Secondly, counsel submitted that the award of aggravated damages was inappropriate. According to him, 'aggravated damages' is actually general damages, with the quantum increased beyond the usual sum so as to compensate the plaintiff for circumstances that aggravated the damage suffered by him. It was contended that aggravated damages should not have been awarded in this case. In support, counsel referred to the English Court of Appeal decision in *Richardson v Howie* and the explanation in Michael Jones, *Medical Negligence* (4th Ed, London: Sweet & Maxwell, 2008).

**[90]** In response, learned counsel for the plaintiff submitted that aggravated damages can be and has been awarded as a separate head of damage in tort cases. It was pointed out that aggravated damages are not excluded from medical negligence or personal injury cases. Counsel further argued that the case of *Richardson* and the contents of para 12-011 from Michael Jones' *Medical Negligence* are no longer applicable. Various authorities were referred to this court to the effect that cases after *Richardson* have continued to award

aggravated damages as a separate head of damages.

*Our decision on the second question*

**[91]** The second question is premised on the basis of the English Court of Appeal case of *Richardson* and the extract from Michael Jones' *Medical Negligence*. The learned author in *Medical Negligence* at para 12-011 elucidated as follows in respect of aggravated damages:

> In practice the issue of aggravated damages may no longer arise in the context of medical negligence cases ... A court should bring that element of compensatory damages into account as part of the general damages awarded. They could not, therefore, properly be characterised as 'aggravated'.
>
> ... The Court of Appeal has made it clear that aggravating factors should be compensated for through the award of 'general damages'. In practice, this is likely to result in awards towards the top end of the appropriate bracket for general damages, if not slightly above.

**[92]** The learned author in making the above assertion was referring to the case of *Richardson*. However, *Richardson* is not a medical negligence case, but an assault case. The issue therein was whether the judge should have included an element for injury to the victim's feelings, including general distress, in his award of general damages; or whether the circumstances were such that aggravated damages should have been awarded. The English Court of Appeal held that:

> It is and must be accepted that at least in cases of assault and similar torts, it is appropriate to compensate for injury to feelings including the indignity, mental suffering, humiliation or distress that might be caused by such an attack, as well as anger or indignation arising from the circumstances of the attack. It is also now clearly accepted that aggravated damages are in essence compensatory in cases of assault. Therefore we consider that a court should not characterise the award of damages for injury to feelings, including any indignity, mental suffering, distress, humiliation or anger and indignation that might be caused by such an attack, as aggravated damages; a court should bring that element of compensatory damages for injured feelings into account as part of the general damages awarded. It is, we consider, no longer appropriate to characterise the award for the damages for injury to feelings as aggravated damages, except possibly in a wholly exceptional case.
>
> Where there is an assault, the victim will be entitled to be compensated for any injury to his or her feelings, including the anger and indignation aroused. Those feelings may well also be affected by the malicious or spiteful nature of the attack or the motive of the assailant, if so, then the victim must be properly compensated for that, particularly where the injured feelings have been heightened by the motive or spiteful nature of the attack. In our view, damages which provide such compensation should be characterised and awarded therefore as ordinary general damages which they truly are. The misapprehension as to the nature of the damages to be awarded for injured feelings which plainly arose in the trial judge's mind and

which led him to award a sum that was wholly extravagant as aggravated damages would not have arisen, if the award had been made as one of ordinary compensatory general damages and not as an award of aggravated damages. The facts of this case clearly did not in any way approach the wholly exceptional case where an award of aggravated damages might still be appropriate.

**[93]** According to the English Court of Appeal in *Richardson*, an award of aggravated damages might still be appropriate in a 'wholly exceptional case'. However, the court did not elaborate on what would constitute such a case.

**[94]** *Richardson* was the sole case relied on by the learned author of *Medical Negligence* for the assertion that aggravated damages may no longer arise in the context of medical negligence. However, *Richardson* is not the authority for the proposition that aggravated damages should not be awarded separately from general damages, as asserted by the learned author. In fact, H McGregor, *McGregor on Damages* (18th Ed, London: Sweet & Maxwell, 2009) (and its Second Supplement (2011)) disapproved of the reasoning in *Richardson*:

> It is difficult to follow the progress of the Court of Appeal's reasoning here. The classification of damages given for injured feelings as compensatory and the classification of aggravated damages as compensatory does not mean that one is not independent of the other and that the one should be subsumed within the other. If the scale or the horror of the assault increases the injury to the claimant's feelings, the damage is aggravated, and hence the damages are aggravated, and the courts have recognised this in their awards. It is true that there does not have to be an amount awarded for aggravated damages separate from the basic award for injury to feelings but the concept of aggravated damages has not only been long recognised but was emphasised and highlighted by Lord Devlin when declaring exemplary damages anomalous in his speech in *Rookes v Barnard*. Aggravated damages should surely be retained in assault cases. This would seem to be accepted by judge and counsel alike in *Lawson v Glaves-Smith* and while in the appeal in *Rowlands v Chief Constable of Merseyside Police*, a claim for damages for assault, false imprisonment and malicious prosecution against the police, the Court of Appeal was concentrating on the imprisonment and the prosecution, counsel having been able to agree an award for the assault, it would seem that the court regarded aggravated damages as applying to all three torts.
>
> The removal of aggravated damages from the tort of assault will create a tension, indeed an inconsistency, between it and other torts where aggravated damages have had judicial blessing by first instance judges and by the Court of Appeal alike. Quite apart from defamation, malicious prosecution, false imprisonment and the statutory torts of discrimination in all of which the writ of aggravated damages undoubtedly runs, if the Court of Appeal is prepared to award aggravated damages against a defendant who damages land, and against a defendant who evicts from land how much more should such damages be available where the damage is to the person, And indeed in *Manley v Commissioner of Police for the Metropolis* [2006] EWCA Civ 987, another claim for damages for assault, false imprisonment and malicious prosecution against the police, the Court of Appeal would appear to have

ignored — if it knew of — what was said in *Richardson v Howie* as the aggravated award of £10,000 which it made was for assault as well as false imprisonment and malicious prosecution.

**[95]** It was also pointed out in *McGregor on Damages* that *Richardson* seems to have been ignored in subsequent English Court of Appeal cases, which continued to make a separate award for aggravated damages. In *Rowlands v Chief Constable of Merseyside Police* [2006] EWCA Civ 1773, the English Court of Appeal held that:

... However, I am unable to accept that the mere fact that the basic award includes an element to compensate for psychiatric harm necessarily precludes an award of aggravated damages. It is now generally recognised that an award of aggravated damages is essentially compensatory in nature, notwithstanding the fact that it may have a punitive effect by increasing the overall amount the defendant is ordered to pay. That was explicitly acknowledged by Lord Woolf MR in *Thompson* as one can see from the passages cited earlier. Whether damages awarded to compensate the claimant for distress, humiliation and injury to feelings are treated as part of the basic damages (as Thomas LJ. Suggested in *Richardson v Howie* [2004] EWCA Civ 1127, (unreported, 13th August 2004) or are separately identified by the name of aggravated damages, the important factor to bear in mind is that they are primarily intended to be compensatory, not punitive. It follows that any injury for which compensation has been given as part of the award of basic damages should not be the subject of further compensation in the form of an award of aggravated damages. However, the distinction between basic and aggravated damages will continue to have a part to play as long as the right to recover for intangible consequences such as humiliation, injury to pride and dignity as well as for the hurt caused by the spiteful, malicious, insulting or arrogant conduct of the defendant attaches to some causes of action and not others.

**[96]** In *Martins v Choudhary* [2007] EWCA Civ 1379, the English Court of Appeal was of the view that there should be no hard and fast rule about whether a separate award should be made and that it all depends on the circumstances and facts of the case. Smith LJ held that:

It is true that one division of this Court did so recommend in the context of a case of modest damages for assault. In Vento, however, another division of this Court approved the making of separate awards for psychiatric harm, injury to feelings and aggravated damages in the context of sex discrimination. I would venture to suggest that there should be no hard and fast rule about whether separate awards should be made. It will all depend on the facts of the individual case. If, for example, as is sometimes the case, the psychiatric harm is very modest and to all intents and purposes merges with the injury to feelings, it will plainly be more convenient to make one award covering both aspects. If, as here, where the psychiatric injury is not insubstantial, it is positively helpful to the parties (and to this Court) if the judge separates the award for psychiatric injury from that for injury to feelings. This leads

A to a better understanding of the judge's thought processes. However, I do accept that there is a risk of double recovery by overlap if two awards are made and the judge must take care to avoid that.

In the present case, I think the judge was justified in making separate awards as she did ...

B

**[97]** In *AT and others v Dulghieru and another* [2009] EWHC 225 (QB), Treacy J made an award of aggravated damages as a separate head from the award of general damages in a sexual assault case:

C These Claimants seek additional compensation in the form of an award of aggravated damages. It is important to be aware of the risk of double recovery. These Claimants must not be compensated twice over for the same injury.

In my award of general damages, I have included an element to cover the psychiatric harm suffered. That however, is to be distinguished from the injury to feelings, D humiliation, loss of pride and dignity and feelings of anger or resentment caused by the actions of the Defendants.

Having regard to the approach taken by the Court of Appeal in *Rowlands v Chief Constable of Merseyside Police* [2006] EWCA Civ 1773; [2007] 1 WLR 1065 and E in particular the observations of Moore-Bick LJ at para 26 of that decision. I consider it appropriate in this case to make an award of aggravated damages. I have also considered the observations of Smith LJ in *Choudhary v Martins* [2007] EWCA Civ 1379; [2008] 1 WLR 617, where at para 18 she observed that it was positively helpful if the judge separated the award for psychiatric injury from that F for injury to feelings. This, she said, was a helpful process as long as the judge takes care to avoid the risk of double recovery.

**[98]** Aggravated damages have in fact been awarded as a separate head of damages by Malaysian courts. In the recent decision of this court in *Mohd* G *Ridzwan bin Abdul Razak v Asmah bt Hj Mohd Nor* [2016] 4 MLJ 282, the High Court's award of aggravated damages was upheld. This court held that:

In appropriate cases, substantial damages may be awarded for any indignity, discomfort or inconvenience suffered; even aggravated damages may be awarded in H light of the motive or conduct of the tortfeasor (*Rookes v Barnard* [1964] AC 1129 (HL) at pp 1121–1123; *W v Meah* [1986] 1 ALL ER 935). As an analogy, in *Appleton v Garrett* [1996] PIQR P 1 aggravated damages were given to patients of a dentist for injury to feelings, mental distress, anger and indignation upon learning that much of the dental treatment given to them was unnecessary and to a large extent performed on healthy teeth. The dentist had deliberately and in bad faith I concealed from them the true condition of their teeth so that he could carry out dental work for profit ...

In the circumstances of this case it was reasonable for the High Court to grant the general and aggravated damages for the proven tort of sexual harassment.

**[99]** It can be seen from the above cases that aggravated damages can be and have been awarded as a separate head of damage in tort. For example, aggravated damages are frequently awarded in defamation cases for injury to a person's reputation. There is no reason to exclude this kind of damages from medical negligence cases, which involve real injury to a person's body. In the circumstances, we answer the second question in the negative. As such, the doctors' appeal on quantum is dismissed.

THE HOSPITAL'S APPEAL

**[100]** The leave question in the hospital's appeal reads as follows:

> Where the doctors are qualified professionals in a private hospital and working as independent contractors by virtue of a contract between the private hospital and the doctor, can the private hospital be held vicariously liable for the sole negligence of the doctors?

*Submissions*

**[101]** Counsel for the hospital submitted that the hospital is not vicariously liable for the negligence of Dr Hari and Dr Namazie. Counsel distinguished the UK cases relied upon on the basis that hospitals in the UK, which are government-run hospitals under the National Health Service; in contrast, private hospitals in Malaysia provide facilities to be rented and used by doctors who cannot afford such facilities themselves. It was asserted that doctors enjoy total independence in the treatment of patients. Additionally, it was also argued that patients are able to inquire about the arrangements between the hospital and the doctors, and to choose from a panel of doctors.

**[102]** It was contended on behalf of the hospital that the plaintiff had not pleaded negligence on the part of the hospital itself. Counsel further asserted the hospital was not vicariously liable for the acts of Dr Hari and Dr Namazie, based on the following factors: that the plaintiff had selected Dr Hari before he went to the hospital; that the plaintiff paid Dr Hari and Dr Namazie for their services; and that Dr Hari and Dr Namazie were both visiting consultants who do not receive salaries from the hospital.

**[103]** Counsel for the plaintiff contended that the question in the hospital's appeal is not applicable, for Dr Hari and Dr Namazie were not independent contractors, but servants or agents of the hospital. Counsel pointed out that the agreement between Dr Hari and the hospital provided for the hospital's control in matters such as patients' medical records, financial matters, drugs, and protocols for consultants. It was argued that an adverse inference should be drawn from the non-production of the employment contract between Dr Namazie and the hospital.

**[104]** In any event, counsel for the plaintiff further submitted that the question was academic in light of the non-delegable duty owed by the hospital to its patients such as the plaintiff. Hospitals, the argument goes, are not merely concrete buildings renting out space for independent practice, but market themselves as comprehensive medical service providers and make profit from their business. Patients visit private hospitals for the hospital's reputation, and expect to receive proper medical care from the hospitals through doctors. It was asserted that hospitals cannot evade liability based on internal arrangements with doctors, of which patients are not aware.

**[105]** On behalf of Dr Hari and Dr Namazie, it was submitted that the plaintiff had no pleaded case against the hospital for direct liability arising out of non-delegable duties. Since it was the position of Dr Hari and Dr Namazie that they were not negligent in the first place, the question of vicarious liability does not arise.

**[106]** We have received further assistance from counsel for the Association of Private Hospitals in Malaysia as amicus curiae. It was submitted that changes in the law in this regard should appropriately be done by the legislature, given the policy implications and the need for consultation with relevant stakeholders. Counsel urged caution in adopting foreign law, noting that the extension of vicarious liability was in response to cases of sexual abuse by caregivers of vulnerable people.

**[107]** Underlining the differences between private hospitals in Malaysia and healthcare systems abroad, it was asserted that private hospitals are seldom more than just spaces for doctors to operate in, whereas doctors operate independently in the treatment of patients. Reference was made to the Medical Act 1971, under which it was submitted that the provision of medical services was an entitlement accorded only to registered practitioners and cannot be undertaken by private hospitals. The amicus curiae considered non-delegable duties as a subset of vicarious liability; since medical practitioners are adequately covered by insurance, the extension of strict liability to hospitals is rendered unnecessary.

*Distinction between vicarious liability and non-delegable duty*

**[108]** A fundamental point needs to be addressed at the outset. It is apparent that counsel for the plaintiff and the courts below have laboured under the (mis)conception that liability for non-delegable duties is subsumed under, or the same as, vicarious liability. The two forms of liability are in fact conceptually distinct. We have most recently elucidated the distinction between non-delegable duties and vicarious liability in the case of *Dr Kok Choong Seng & Anor v Soo Cheng Lin and another appeal* [2018] 1 MLJ 685:

> Non-delegable duties have been erroneously considered as a 'kind of vicarious liability', and adopted as part of the test to determine vicarious liability in some cases. This is a misconception. The two doctrines are similar in effect, in that they both result in liability being imposed on a party (the defendant) for the injury caused to a victim (the plaintiff) as a result of the negligence of another party (the tortfeasor). However, it bears emphasis that non-delegable duties and vicarious liability are distinct in nature and basis. The former imposes personal liability on the defendant for the breach of his own duty towards the plaintiff, based on the relationship between the defendant and the plaintiff, regardless of whom the defendant has engaged to perform the task. The latter imposes vicarious liability on the defendant for the tortfeasor's breach of duty towards the plaintiff, based on the relationship of employment between the defendant and the tortfeasor.

**[109]** It was contended before us that the issue of non-delegable duties should not be allowed to be raised, since the plaintiff had not pleaded direct liability on the hospital's part for negligence. From a careful reading of the pleadings, this is not the case. We note that the plaintiff had pleaded particulars of the hospital's own negligence in the statement of claim; in his reply to the hospital's defence, the plaintiff had also alluded to the hospital's duty of care to the plaintiff to ensure that a competent standard of practice is exercised during the operation. Since 'the nature of a non-delegable duty is, in essence, a positive duty to ensure that reasonable care is taken' (*Dr Kok Choong Seng*), we find that the essence of a non-delegable duty have been sufficiently pleaded.

**[110]** In this case, without the benefit of this court's clarification in *Dr Kok Choong Seng*, the High Court and the Court of Appeal below appear, in their reasoning, to have erroneously determined the hospital's vicarious liability on the basis that it is one and the same as liability for non-delegable duties. Leave was granted to appeal against the Court of Appeal's decision on vicarious liability. In the circumstances, we find that no injustice is caused to the parties by allowing the issue of non-delegable duties to be ventilated and considered at this juncture. In answering this question, we will analyse the alleged liability of the hospital in terms of vicarious liability and non-delegable duties separately.

*Vicarious liability*

**[111]** We are invited to consider whether private hospitals, having contracted with doctors to work as independent contractors, can be held vicariously liable for the sole negligence of doctors. We have answered a similar question in the recent case of *Dr Kok Choong Seng*, wherein we considered the expansion of the scope of vicarious liability in *Various Claimants v Catholic Child Welfare Society and others* [2013] 2 AC 1. In summary, the test for imposing vicarious liability on a defendant (D2) for the tortious act of a tortfeasor (D1) comprises two stages:

A (1) the relationship between D1 and D2 must be one of employment or sufficiently akin to employment; and

(2) there must be a sufficiently close connection between that relationship and D1's tortious act.

B

**[112]** The determination of a relationship of employment (or akin to employment) at stage 1 requires a consideration of multiple factors. In this exercise, the degree of control exercised by D1 over D2 is an important, albeit non-determinative, factor. Other factors include whether D2's activity was part C of D1's business activity, and whether the tort was committed as a result of D2's activity done on behalf of D1. In *Dr Kok Choong Seng*, this court explained that:

> The determination is a question of fact, based on a consideration of multiple factors and calls for an evaluative judgment. The terms regulating the general relationship D between a hospital and a practitioner, and the particular terms applicable in the circumstances of the alleged negligence, may vary from case to case. As such, the vicarious liability of the private hospitals for the torts of medical practitioners cannot be determined with a broad brush in a factual vacuum.

E

**[113]** It was also highlighted in *Dr Kok Choong Seng* that the expansion of vicarious liability to include relationships akin to employment in *Various Claimants* was in the peculiar context of sexual abuse perpetrated by an association of Christian brothers. The expansion to include relationships akin F to employment was not meant to cover 'truly independent contractors'. It is worth reiterating the observation by Lord Sumption in *Woodland v Swimming Teachers Association and others* [2014] AC 537:

> The boundaries of vicarious liability have been expanded by recent decisions of the courts to embrace tortfeasors who are not employees of the defendant, but stand in G a relationship which is sufficiently analogous to employment: *Various Claimants v Catholic Child Welfare Society* [2012] UKSC 56; [2013] 1 All ER 670; [2013] 2 AC 1. *But it has never extended to the negligence of those who are truly independent contractors*, such as Mrs Stopford appears to have been in this case. (Emphasis added.)

H

**[114]** Thus we would answer the question posed in the hospital's appeal in the negative: where the doctor is ascertained to be a truly independent contractor in the circumstances, the private hospital cannot be held vicariously liable for the sole negligence of that doctor. The true relationship between a private I hospital and a doctor practising therein must be determined from the relevant contractual terms and the factual circumstances of the case.

**[115]** In the instant case, it is not apparent that the courts below have made a finding on the employment status of Dr Hari and Dr Namazie. The High

Court held that the hospital allowed the two doctors to 'hold themselves out as agents or servants/employees' of the hospital, and stopped short of stating whether they were in fact employees. The Court of Appeal held: 'We do not agree with the submission of the third defendant that the defendant doctors were independent contractors and not its employee and hence cannot be held vicariously liable'. The statement was then followed by references to literature and cases to the effect that the hospital owed a direct duty of care to its patients, and it was irrelevant whether the performance of that duty was delegated to an employee or an independent contractor. Thus, the Court of Appeal did not make a finding that Dr Hari and Dr Namazie were independent contractors; on the contrary, it was held that the hospital was liable to the plaintiff *regardless* of the employment status of the two doctors.

**[116]** In the absence of such a finding, we will proceed to consider the evidence to ascertain whether the relationship between the hospital and Dr Hari or Dr Namazie is one of employment or akin thereto, such as to give rise to vicarious liability.

*Dr Hari*

**[117]** We first consider the relationship between the hospital and Dr Hari. Dr Hari and the hospital have signed a 'Consultant's Agreement for Use of Hospital Facilities and Services', the salient terms of which are as follows:

(a) Dr Hari is deemed to be an independent contractor and not a servant or agent of the hospital;

(b) Dr Hari shall comply with the hospital's directions and regulations, but such directions and regulations shall not impinge upon consultant's exercise of professional judgment in the care of his patients;

(c) Dr Hari shall provide professional services for outpatients on a sessional basis in the hospital, during such periods as may be determined by the hospital;

(d) Dr Hari may book operating sessions in the hospital for inpatients;

(e) Dr Hari shall charge fees to his patients, which would be collected by the hospital and remitted to him monthly;

(f) the hospital shall charge Dr Hari fees for facilities and services; and

(g) Dr Hari shall ensure that he is covered by insurance, and shall indemnify the hospital against all liability resulting from his neglect or default.

**[118]** It is recalled that the finding of negligence was against Dr Hari for his diagnosis, advice and treatment of the plaintiff: specifically, the negligent acts were advising the plaintiff to undergo the unnecessary second operation, failing

to advise the plaintiff of the risk of bucking and blindness, and using the wrong procedure during the second operation. There was no finding of negligence relating to the provision of drugs, facilities or medical records by the hospital. As such, the relevant factors in the present case concern Dr Hari's *advice and conduct* of the second operation: these include whether such advice and conduct were subject to the hospital's control, done on behalf of the hospital, or a part of the hospital's business activity.

**[119]** The plaintiff was referred to, and first consulted, Dr Hari at his private clinic, where Dr Hari then diagnosed the plaintiff's condition and advised him to undergo the first operation. Based on Dr Hari's own testimony, the appointment with the plaintiff on 21 September 1999 was a follow-up appointment after the first operation, and the second operation was only decided on that date. Dr Hari then referred the plaintiff to the hospital for admission and conducted the second operation in the hospital. It is clear from the entire sequence of events that Dr Hari's diagnosis of the plaintiff's condition, advice to undergo the second operation and conduct of the second operation were done in the course of Dr Hari's private practice. We find no evidence that the hospital exerted any control over Dr Hari's advice and conduct of the second operation, whether over *what* Dr Hari did or *how* he did it. 'The absence of even that vestigial degree of control would be liable to negative the imposition of vicarious liability' (per Lord Reed in *Cox v Ministry of Justice* [2016] AC 660).

**[120]** We consider that Dr Hari's advice and conduct of the second operation were attributable to his own recognisably independent business. The mere change in location to the hospital for the follow-up appointments on 14 September 1999 and 21 September 1999, and the use of the hospital's facilities in conducting the second operation, did not change the independent nature of Dr Hari's business in his treatment of the plaintiff. Further, the structure of fees is also not indicative of a contract of service between employers and employees: Dr Hari charges his own fees to his patients, and is required to pay fees for using the hospital's facilities and services. The hospital's role in collecting the patient's fees and remitting them to Dr Hari is administrative in nature. It can be inferred from these circumstances that Dr Hari's advice and conduct of the second operation were not done on behalf of the hospital, and was not a part of the hospital's business activity.

**[121]** Striking parallels may be drawn with the facts in *Dr Kok Choong Seng*. As in the present case, the patient had first consulted the surgeon at his private clinic, and it was only upon the advice and referral of the surgeon that the patient was admitted to the hospital for an operation. At the hospital, the surgeon negligently conducted the operation and the patient suffered injuries. The operation was not done in the course of any clinical session required by the

hospital. The consultancy and operation fees were charged on the patient by the surgeon, who received no salary from the hospital. In all the circumstances, it was held that the surgeon and the hospital were not in a relationship of, or akin to, employment so as to give rise to vicarious liability on the hospital's part.

**[122]** Following *Dr Kok Choong Seng*, we find that in advising the plaintiff on and conducting the second operation, Dr Hari was indeed acting in the capacity of an independent contractor and not an employee of the hospital. As such, no vicarious liability can be imposed on the hospital for Dr Hari's negligence.

*Dr Namazie*

**[123]** We turn to consider the relationship between the hospital and Dr Namazie. In this regard, we note that several aspects of Dr Namazie's evidence during cross-examination were unchallenged. Dr Namazie testified, among others, that he was requested to provide his services to the hospital by the latter's medical director on a temporary basis while the resident anaesthetist was on maternity leave, and accordingly he was on duty for all operations requiring general anaesthetics on the day of the second operation.

**[124]** It was also the evidence of Dr Namazie that while he was a visiting consultant to the hospital, he had no clinic in the hospital. The management of the hospital could not interfere with Dr Namazie's work: they could not prescribe the type or amount of gases to be administered to the patient, nor dictate Dr Namazie's hours of work. In addition, he was not paid by the hospital for the services he rendered. The fees for his services were paid by the patient to Dr Namazie through the hospital, and the hospital's role in collecting the fees was purely a matter of administrative convenience. These factors are characteristic of a contract for services with independent contractors, rather than a relationship of employment.

**[125]** We were invited by counsel for the plaintiff to draw an adverse inference from the hospital's failure to produce the contract signed with Dr Namazie. However, since Dr Namazie's testimony in the above respects were unchallenged and no evidence was adduced to the contrary, we do not consider such a finding to be of any significant weight in our determination.

**[126]** Weighing the evidence as a whole, we consider that Dr Namazie was also an independent contractor of the hospital, and accordingly we find that the hospital is not vicariously liable for the negligence of Dr Namazie in the second operation.

*Non-delegable duty*

**[127]** We now focus on the relationship between the hospital and the plaintiff. Where a hospital is held to owe a non-delegable duty to its patient to ensure that reasonable care is taken in his treatment, the hospital may be held liable to the patient if the duty is breached, regardless to whom performance of that duty is delegated. A classic formulation of such a duty was expressed by Denning LJ in *Cassidy v Ministry of Health* [1951] 2 KB 343:

> I take it to be clear law, as well as good sense, that, where a person is himself under a duty to use care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation be to a servant under a contract of service or to an independent contractor under a contract for services.

**[128]** The concept of non-delegable duties was affirmed in *Dr Kok Choong Seng*, in which this court analysed the nature of non-delegable duties as a 'positive duty to ensure that reasonable care is taken'. The defining features of non-delegable duties arising out of a special relationship as set out in *Woodland* were adopted in *Dr Kok Choong Seng*, and these features may be broadly summarised as follows:

(a) the claimant is especially vulnerable and dependent on the defendant's protection from the risk of injury. Such claimants include, but are not limited to, patients and children;

(b) there is an antecedent relationship between the claimant and the defendant, from which to impute an assumption of responsibility on the defendant to protect the claimant from harm. The relationship places the claimant in the defendant's actual custody or care;

(c) the claimant has no control over how the defendant chooses to perform the duty assumed, whether personally or otherwise;

(d) the defendant has delegated to a third party a function which is an integral part of its positive duty towards the claimant, and also the custody and control incidental to that function; and

(e) the third party was negligent in the performance of the very function assumed by the defendant and delegated to him.

**[129]** It is convenient at this juncture to deal with the argument raised by counsel for the hospital that private hospitals in Malaysia, being different from the National Health Service hospitals in the UK, are by nature invariably immune from liability for non-delegable duties to patients. This contention has been rejected in *Dr Kok Choong Seng*. In respect of the legislative scheme under the Private Healthcare Facilities And Services Act 1998 and the relevant

regulations, this court has held that:

> Read in their entirety, we do not consider that the relevant legislation warrants the interpretation that private hospitals are mere providers of facilities and not medical treatment. On the contrary, the legislative scheme clearly envisages that the function of private hospitals includes generally the 'treatment and care of persons who require medical treatment or suffer from any disease', and considers the services of medical practitioners as part of that function. The notion that the duty of a hospital is confined only to its facilities and staff selection has long been rejected in the common law. Such a notion is also incongruent with societal expectations of private hospitals as healthcare service providers; most patients do not perceive hospitals as providers of all the utilities and backup services except medical treatment.

**[130]** We also note the amicus curiae's contention that private hospitals cannot undertake the provision of medical services, which is the sole privilege of registered doctors under the Medical Act 1971. However, we do not consider that such an interpretation can be read into the provisions in the Medical Act 1971, which merely enumerates the requirements for the registration of medical practitioners. The idea that private hospitals are invariably nothing more than just spaces for doctors to operate in is neither warranted by the legislative scheme as a whole, nor congruent with societal expectations. As this court has held in *Dr Kok Choong Seng*:

> Given that the role of the hospital may vary from patient to patient, the extent and scope of the hospital's duty towards the patient must be ascertained from the facts and circumstances of the case.

**[131]** We now return to the *Woodland* test as set out above. Applying the *Woodland* features to the present facts, we have no difficulty in establishing the first feature: it is indubitable that the plaintiff, as a patient admitted in the hospital for the second operation, fell into the category of especially vulnerable persons and was dependent on the hospital for protection.

**[132]** In respect of the second feature, the plaintiff was undoubtedly placed in the hospital's custody or care upon admission for the purposes of the second operation. The scope of the positive duty assumed by the hospital, if any, must be determined by a careful examination of the circumstances. It is significant that the plaintiff was referred to Dr Hari at his private clinic by another doctor, and initially consulted Dr Hari there for diagnosis and advice in relation to his right eye. It was only upon Dr Hari's advice and referral that the plaintiff was admitted to the hospital for both the first and second operations. Given these circumstances, it was irrelevant to the relationship between the plaintiff and the hospital whether Dr Hari was held out as an agent or employee by the hospital.

**[133]** Further, the plaintiff's expectation was that the second operation was to be conducted by Dr Hari. The role of the hospital was confined to providing the necessary facilities and services for the second operation. While Dr Hari's advice to conduct the second operation was given to the plaintiff in the hospital's premises, the appointment was a follow-up to the previous consultations between Dr Hari and the plaintiff. Taking the sequence of events as a whole, we consider that the hospital had not assumed responsibility to the plaintiff for the advice and conduct of the second operation. On the contrary, the diagnosis and treatment of the plaintiff's right eye, including the second operation, was arranged between the plaintiff and Dr Hari as part of the latter's private practice.

**[134]** These facts are materially similar to the facts in *Dr Kok Choong Seng*, wherein the hospital was held not to owe a non-delegable duty to the patient in respect of the operation arranged in a similar manner by the surgeon. The patient's personal choice of the surgeon at his private clinic was held to be a relevant consideration in negating an assumption of responsibility by the hospital for the conduct of the operation.

**[135]** However, it is at this juncture that the similarities end. As far as the plaintiff was concerned, the plaintiff was dependent on the hospital for the facilities and services indispensable for the second operation, including anaesthetic services. It was unchallenged that Dr Namazie was requested by the hospital to provide his anaesthetic services at the material time, while the resident consultant anaesthetist was on maternity leave. The plaintiff was left with no choice of anaesthetist for the second operation; in fact, the plaintiff had initially requested for another anaesthetist — one Dr Manavalan who attended to him in the first operation — but was informed that Dr Manavalan was not available at that time. Dr Namazie was the only anaesthetist on duty on the day of the second operation, and he was involved in all operations at the hospital which required general anaesthetics on that day.

**[136]** It can be inferred from these facts that the hospital, being the provider of anaesthetic services through Dr Namazie, had assumed a positive duty to the plaintiff to ensure that reasonable care was taken in the provision of such services by whomever the hospital engaged to do so. As such, we find that the second feature is satisfied.

**[137]** We find that the third, fourth and fifth features of non-delegable duties are also satisfied. In respect of the third feature, as alluded, the plaintiff had no control over how the hospital chose to provide anaesthetic services for operations conducted therein, whether by delegation to employees or otherwise. In any event, the plaintiff could not have been reasonably expected to know the internal arrangements between the hospital and the anaesthetist on

duty on the day of his operation. This is further supported by the evidence that the anaesthetist's name was not displayed as a visiting consultant on the signboard at the hospital's reception area at the material time.

**[138]** In respect of the fourth feature, the hospital had delegated to Dr Namazie the responsibility to administer doses properly so as to keep the plaintiff anaesthetised throughout the second operation. This is an integral part of the positive duty assumed by the hospital to the plaintiff, to ensure that care is taken in the provision of anaesthetic services.

**[139]** In respect of the fifth and final feature, Dr Namazie was negligent in the performance of the duty delegated by the hospital to him, in mistiming the top-up dose and thereby causing the plaintiff to regain consciousness and buck during the second operation.

**[140]** Therefore, applying the principles in *Woodland*, we conclude that the hospital owed a non-delegable duty to the plaintiff to ensure that reasonable care was taken in the anaesthetic services provided, and we hold the hospital liable for the breach of this duty.

*Policy*

**[141]** We need to address a final point on this issue. Policy considerations have been advanced by both parties in arguing whether private hospitals should or should not *generally* be held liable for the negligence of its doctors. For the hospital, it was contended that the establishment of private hospitals is in accordance with the government's call to alleviate the burdens faced by public hospitals, and imposing vicarious liability on private hospitals would lead to higher costs being passed on to patients. For the plaintiff, it was argued that that as profit-making enterprises private hospitals should be under a liability equal to that of public hospitals, and that the imposition of liability would hold private hospitals to higher standards.

**[142]** While the clarification in *Dr Kok Choong Seng* is a useful starting point in providing a framework for analysing liability for injuries caused by employers or independent contractors, we are mindful that the law on vicarious liability and non-delegable duty is in ongoing development. We would take heed of the proviso in *Woodland* to 'proceed with caution, incrementally by analogy with existing categories, and consistently with some underlying principle', and to impose liability 'only in so far as it would be fair, just and reasonable'. To make a broad pronouncement on the liability of *all* private hospitals in medical negligence cases on the basis of policy alone would risk over-generalising the nuances of modern business relationships, and result in an unprincipled approach to liability.

**[143]** For the above reasons, we dismiss the hospital's appeal and hold the hospital liable for breach of a non-delegable duty to the plaintiff.

CONCLUSION

**[144]** In view of the foregoing, we dismiss the doctors' appeal and the hospital's appeal with costs. We hold Dr Hari and Dr Namazie liable in negligence in their advice, diagnosis and treatment of the plaintiff, and we hold the hospital liable for breach of its non-delegable duty to the plaintiff. The award of damages by the High Court is affirmed.

*Appeals dismissed with costs.*

Reported by Afiq Mohamad Noor